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CONTRIBUTIONS OF PSYCHOLOGICAL MEDICINE
TO THE ESTIMATION OF CHARACTER
AND TEMPERAMENT.

By R. D. GILLESPIE.

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I. INTRODUCTION.

THE allied subjects of temperament and character are among the most important in psychology; yet in the field of normal psychology at least they have been among the most neglected. The text-book discussion of these topics has usually been disproportionally brief, and where it has not been brief it has not been helpful. This comparative neglect undoubtedly depends largely on the exceptional difficulty of the problems which are involved from the start. It has been said that tests of temperament and character are nowadays in the position in which tests

of intelligence stood twenty years ago; and a corresponding advance in the early future has been anticipated. An examination of the methods at present in use and of the theoretical formulations on which the methods are based in the study of normal temperament and character hardly nourishes such optimism. It is notorious that normal psychology as that term is generally defined has failed to make fundamental contributions to the understanding of the abnormal character and conduct that appear in mental 'disease.' To assess the responsibility for this failure would be an invidious task, but a perusal of what normal psychology has had to offer suggests that the fault has not lain altogether with those who have approached the question from the abnormal aspect. On the other hand, the problem suggests itself to discover how far the study of the deviations of temperament and character found in mental illness can help to clarify the problems presented by normal psychology in these spheres; and especially what data may be obtained from psychological medicine for estimating the character and temperament of any individual normal or pathological.

It is but natural that the psychiatrist should have devoted himself more to the study of these topics than to the investigation of levels of intelligence; partly because marked variations in them come perhaps more commonly to his notice than examples of intellectual defect; and partly because they are often capable of modification in a way that mental deficiency in the sense of intellectual defect never is.

2. TERMINOLOGY.

It has become conventional in psychological medicine to include both character and temperament under the single term 'personality,' not only as a matter of convenience, but for clinical reasons. The philosophical connotations of 'personality' are numerous and usually obscure; in psychiatry, however, the term is used to cover not merely the sum of temperament and character, but their product in the behaviour of the individual. It is in this sense that the term 'personality' occurs in clinical psychiatry and it will be so used in this paper. Nevertheless, because of the many meanings which the term has assumed, and because of the limitations of its own root-meaning, it would be desirable for psychiatric and general psychological purposes to replace 'personality' in this sense by a more distinctive word. It happens that there is already in English a word which, although degraded and misunderstood in ordinary speech, stresses exactly what from every aspect it is desirable should be emphasized in this connection—the manner in which traits

of temperament and character are synthesized or integrated to form the 'personality.' The word 'idiosyncrasy' is derived from 'krasis' meaning mixture. The meaning of idiosyncrasy is 'peculiar mixture,' and according to Fowler⁽¹⁾ "the point of it is best shown in the words that describe Brutus:

His life was gentle, and the elements
So mixed in him, that Nature might stand up
And say to all the world 'This was a man.'

One's idiosyncrasy is the way one's elements are mixed.... The continued existence of idiosyncrasy in its proper sense is very desirable.... Thus it is reasonable to say that a person has... no individuality; but a person without an idiosyncrasy [in this sense] is inconceivable.... Idiosyncrasy means all the ingredients of which a man is composed, and their proportions and reactions—a valuable compound notion that we may be thankful to find compressed into a single word." It is suggested, therefore, that a word so well vouched for by a philologist, and so precisely adapted to the work psychology requires of it, should be used instead of 'personality' to designate the peculiar integration of character and temperament which we regard as constituting the individual as we know him. If this conception of 'idiosyncrasy' is practically valid, the attempt to discern 'character-types' is principally an exercise in academic formalism.

This paper is not, however, primarily concerned with the general concepts of character and temperament, but with the assessment of them in the individual, and especially with the hints for normal psychology that may be derived from studying their aberration. Nevertheless, in the course of an investigation of this kind, some suggestive contributions may be offered for the elucidation of the general concepts.

It is appropriate to consider first, the data obtainable regarding character and temperament from direct observation of persons showing aberrations of them; for, since the deviations from the normal are so often in the direction of excess of certain qualities, these should presumably be the more readily detectable and the more readily assessed. If this presumption proved to be justified, an opportunity would be afforded of determining more definitely what are the outward marks of certain temperamental dispositions and character traits.

3. METHODS OF DIRECT (CONTEMPORARY) OBSERVATION.

(a) Clinical observation.

So far as temperament in the sense of emotional disposition is concerned, the expectation that the study of the abnormal might yield useful clues to the direct assessment of prevailing temperamental conditions in the normal is hardly fulfilled. Indeed, the lessons to be derived from psychiatric experience are chiefly those of the intricate complexity of emotional states, and of the great difficulty of discerning even their immediate presence with exactitude. The clinical psychiatrist suffers from the difficulty of distinguishing not merely the quantity but sometimes even the quality of the emotion that he is endeavouring to evaluate—and this in spite of its morbid intensity and persistence. The mental patient, no less than the normal person, has a difficulty in describing his affective condition as it appears subjectively to him. The language of the emotions is notoriously deficient at any time. It is one of the standing difficulties in the psychiatric examination of a patient that there is no unequivocal phrase in which to couch an inquiry about the patient's mood. Such queries as *How do you feel?* *How are your spirits?* are commonly used; but their usefulness arises perhaps less from any specificity of meaning, than from their effect in directing the patient's attention to his present affective experience. Their ability to elicit appropriate replies depends almost as much on the general trend of the conversation as on the shaping of the queries themselves; and the patient's intelligence, education, and introspective aptitude are also decisive factors in the relevance of the reply that is obtained. With some patients, either of the 'extravert' type, or with a modest degree of intelligence, the replies elicited may refer principally to feelings of bodily health—of general malaise or some kindred change in the general coenaesthesia rather than to the affective (emotional) condition. There is also the difficulty, even where we succeed in conveying to the patient the aim of our inquiry, that the words which he uses to express the affective quality may have a peculiar personal connotation which is not conveyed to his interlocutor. Thus the man who, as far as can be judged on all other grounds, is 'depressed' (*i.e.* sad) may simply complain of feeling 'dull,' and may actually deny being 'sad' if the latter term is offered to him specifically.

It will be promptly urged, with justification, that this method by question and answer is a poor means of arriving at anyone's affective condition, especially in persons so emotionally disturbed that outward

and visible signs of the disturbance might reasonably be expected. But unfortunately the outward signs of affective disturbance, even when the latter are profound, are exceedingly uncertain. The difficulty of judging immediately-present emotional conditions from face and bodily posture, especially in adults, is well known to students of the normal(2). Experiments on this subject have shown the comparatively low reliability of many such judgments. The clinical study of the abnormal reveals additional and otherwise unsuspected difficulties. Thus, there is often a dissonance of affect and expression, which may be independent of any artfulness on the part of the patient. Certain patients, suffering from profound remorse or in a state of complete hopelessness, may smile and be superficially cheerful at an interview, and may within an hour or two, if given the chance, make a determined attempt at suicide. Usually, however, patients so distressed as this do display the lineaments of sadness (the drooping jaw and mouth, the heavy upper eyelids) or of extreme anguish or apprehension. Such outward expressions are obvious only in those too distressed to conceal them, or in those who for reasons of their own wish to parade their discomforts. There is a large number of patients in whom the outward signs of a morbid affective state are little if at all visible at any time, and they not uncommonly complain that they receive no sympathy from onlookers because they seem so healthy and show little facial or other evidence of the perturbation within. In certain conditions where there is organic brain disease affecting the mimic musculature the difficulty of estimating the underlying emotional condition is, of course, increased. Thus, the wooden immobile facies of the patient with chronic encephalitic Parkinsonism is well known, and although it is sometimes accompanied by the apathy which it seems to express(3), more often it veils a feeling of grief and despair at the disability which the disease imposes. Such conditions are, however, comparatively rare, and in most of our patients the difficulty lies not in disability of the appropriate musculature, but in the inadequacy of the means of expression even at their best, whether through the normal musculature, or by verbal description.

The examination of yet another type of mental disorder yields evidence of more profound disharmonies in the relation of prevailing affect to expression, and of a complexity otherwise unsuspected of inner relationships between affective conditions themselves. The essence of advanced schizophrenic deterioration (dementia praecox) appears to be disintegration of the personality, involving not only temperamental alterations but changes in the manifestations and relationships of

primary affects to one another and to the rest of the mental content. Thus affect and utterance no longer correspond as in the normal—the patient may display indifference or even apparent happiness while relating in a disconnected way the occurrence to himself or to his friends of experiences which would ordinarily be heart-rending. Moreover, all sorts of affects may follow each other with little apparent relation to the mental content at the time. Affective disturbances occur which the patient is unable to account for, and he is apt to attribute them to influences malign or benignant, coming from without. The result of this medley of conditions is that the patient's facial expressions may express affects which he, as a 'personality,' does not feel; or he may feel affects which his facies does not express. He smiles, and does not know why he smiles, or he feels happy or sad, and yet has the appearance of apathy. (It should be mentioned that some writers, *e.g.* Sullivan (4), contend that these discrepancies are impressions on the part of the observer, and do not tally with the actual state of affairs. But we are here dealing with impressions.) Equally important is the well-known ambivalence that may exist in the affective attitude of schizophrenics, the same object arousing apparently (but perhaps not actually) simultaneous opposite and ordinarily incompatible emotional responses. The classical example is the parallel existence of love and hate towards the same person with a characteristic lack of reconciliation of the two types of response, so that neither is tempered by the other, and both in consequence are capable of expression in a singularly immoderate and mutually contradictory way. But the same duality is apparent throughout all the schizophrenic's affective responses; so that the patient wants and does not want a thing, obeys and refuses, laughs and weeps in response to the same stimulus, the particular response varying in apparently arbitrary fashion but actually in accord with the shifting internal setting of the moment.

It is clear, therefore, that in morbid conditions the estimation of the contemporary affective condition from the study of expression, verbal, facial or postural, so far from being easier than in the normal, is more complicated. The lesson principally to be deduced is in fact that of a complicated difficulty unsuspected in normal persons but nevertheless existing in all probability also in them in certain circumstances. Ambivalent attitudes are apparent in any close study of a normal person's relationships to those persons who mean most to him. Emotional states, insufficiently accounted for by the accompanying content of unconsciousness, are common enough in all of us—transient elations

and depressions, mild conditions of anxiety that we would find it difficult to analyse, occur from time to time in our daily experience. MacCurdy (5) has given examples of short-lasting elations dependent on (forgotten) dream experiences of the preceding night, and lasting unaccountably to consciousness for some hours during the day. Normal persons do not however experience affects which have no feeling of intimacy, and which on the contrary feel as if they were externally imposed.

In the light of the complications just discussed, it is difficult to see how the 'general emotional factor' which some have suggested is to be discerned, and in view of clinical experience obtained by the biographical methods described below, the value of such a hypothesis is hard to imagine. Presumably a general factor of this kind would be thought of in terms of intensity, and would be so measured, if measurement became possible. But emotions have other qualities besides intensity that are equally important, and more readily observed, namely, duration and variability. To define and measure a general emotional factor in terms of intensity would therefore be to allow important emotional attributes to escape, and would furnish a very inadequate instrument. Moreover, as far as clinical experience enables us to judge, it is doubtful whether the isolation of a general factor would have much utility; for the impression gleaned from the biographical study of temperament is on the whole of the one-sidedness of the emotional tendencies of a given individual. For example, the depressive psychotic has commonly displayed depressive reactions habitually in his previous history, and the attitude of the person who develops an anxiety-state usually has been timid and fearful. When they have been emotionally affected in an opposite direction, their joyfulness has been anything but robust. In other words, the specific factors that would have to be postulated would be so large, and the general factor so comparatively small, that the usefulness and even the validity of the hypothesis of a general factor would become extremely doubtful.

(b) Instrumental methods.

If from the uncertainty of clinical criteria derived from direct observation we turn to instrumental methods of discerning affective conditions immediately present, it might be reasonable to expect once more that the crude emotional disturbance of mental 'disease' would furnish a useful subject for experimentation. Full-blown, long-lasting affective states should presumably produce large instrumental deviations. But psychogalvanometric studies in the psychoses, so far as it is

practicable to make them, have failed to furnish utilizable data either for the detection of a *continued* emotional state, or for discerning its special quality; nor does it seem likely that they will ever do so. Thus, there is no discoverable quantitative relationship of galvanometric deviations with, *e.g.*, depth of continuous emotional depression (sadness); nor is there anything in the electrical resistance of the body that will serve to differentiate depression from elation; and there is no form of galvanometric response to a stimulus which is characteristic of either condition. If the very profound sadness that occurs, *e.g.*, in involuntional melancholia gives in the galvanometric curve no differential clue to its presence, there is little hope of utilizing the galvanometer as a detector of prevailing affective states in the normal, although of course changes of affect may be discoverable by this means, probably without specific indications of the direction of the change (6).

Of other instrumental means of determining emotional conditions, the less said of blood-pressure (7) and the oculo-cardiac (8) reflex and the like, the better. They exhibit no useful correlations and far too much has been made of them already. There are, of course, a number of bodily changes which go with profound emotion (tremor, as in fear: or diminished tone of unstriated muscle, as in depression); but where these changes are sufficiently marked to be unequivocal, the emotional condition of which they are the partial expression is invariably discernible on other grounds. It is conceivable that to each quality of emotion there corresponds a specific kind of bodily change; but so far the investigation of abnormal conditions has given no clue to what that kind of bodily change may be.

4. DIFFICULTIES OF IMMEDIATE CLINICAL OBSERVATION.

The handicap imposed by the ineffectiveness of our methods of detecting the existence or the quality of emotional responses in an individual under examination is nowhere more evident than in our dealing with the class of 'temperamental defectives' or constitutional psychopaths, or (to use the official label where there is some co-existing intellectual defect) 'moral imbeciles.' Our principal method—that of obtaining the product of the patient's frank introspection—is here inapplicable, for the honesty of the emotionally defective individual is itself impugned: hence we have to do without his full co-operation. In children it is not so difficult, for they are less artful in concealment, and the lack of emotional reaction when plain misdemeanours are referred to, and the facile lying and obvious inconsistency of their statements,

may sometimes make the diagnosis easy. But in adolescents and in adults of this class, if personal data from unbiased sources regarding their previous behaviour is lacking, it may be difficult to detect anything definitively abnormal during a single interview.

So far, this discussion has been concerned with the methods of detection of the immediate presence of emotional reactions. It will be seen that the study of mentally abnormal persons, so far from affording clues in this direction, serves principally to emphasize still further the complexities of the phenomena we seek to discover. But temperament, and still more, character, involves not so much immediate emotional responses, as the type and the general conditions under which they appear, their readiness to be elicited, their persistence and the like. It is here that psychological medicine has a contribution, or at least an emphasis, to make.

5. THE BIOLOGICAL APPROACH TO THE STUDY OF TEMPERAMENT AND CHARACTER.

The contribution and the emphasis are fourfold.

In the first place, the only satisfactory criteria of temperament and character are those supplied by the test of life. The biographical method of investigation, commonly called in clinical psychiatry history-taking, is indispensable. Secondly, a mere history of traits is of little avail without an account of their integration—the manner in which they work together as ‘character’; and the formal categories of emotions usually adopted in normal psychology require some modification and amplification in the light of psychopathological experience. Thirdly, separate traits lose much of their significance, and may in fact be misleading, unless they are analysed in a ‘genetic-dynamic’ way⁽⁹⁾. Finally, certain attributes, temperamental and characterological, are of much greater importance than others in determining the success of the individual’s adaptation to life—and it is after all with the answer to the question “What are this individual’s chances of making and preserving a successful adaptation in his way through life, and under what circumstances is he most likely to do so?” that any study of personality is primarily and fundamentally concerned. The first and third of these points may be taken together; and the second and fourth likewise.

6. ‘GENETIC-DYNAMIC’ ANALYSIS OF INDIVIDUAL TRAITS.

Although it has been universally recognized that even the persistent traits of a person’s behaviour are not always to be taken at their face

value (as, for example, evangelical and philanthropic endeavours), it is perhaps more to Freud than to anyone else that we owe the demonstration of the possibilities of analysing characterological and even some temperamental traits into their components by means of an intimate biographical method. The term 'possibilities' is here used advisedly, because it is not yet justifiable to accept his conclusions in this field for individual cases as universal; and not always as valid even in individual cases. Moreover, it is here assumed as a likely hypothesis that some normal traits at least are acquired in a fashion similar to that about to be described for abnormal ones. The limits of acceptability are, however, a matter for another and different discussion from this one, which will be confined to drawing attention to the importance of certain of Freud's analytic and synthetic conceptions in explaining the genesis of certain traits and the unsuspected relationships that can by his method be discerned between traits apparently widely different. An example is furnished by his analysis of the origins of the orderliness, obstinacy and parsimony which are found together, according to Freud, in certain persons. In such people he claims to have demonstrated an unusually emphatic direction of early erotic interest towards the anal zone. In later (adolescent and adult) life conscientiousness and excessive orderliness appear as reactions against the early unconscious interest in things now regarded as unclean; such obstinacy and parsimony being sublimations (transformations to a socially higher level) of the original interest. The general conclusion that Freud reaches in his essay on "Character and Anal-erotism" is this: "the permanent character traits are either unchanged perpetuations of the original impulses, sublimations of them, or reactive-formations against them." This may be construed as identical with a statement that the permanent character traits are either identical with or analogous to, or the opposite of, the original impulses—not a very helpful conclusion. But in fact two important principles are suggested, even if the example of anal-erotism may to some seem unacceptable; first, the possibility of tracing the natural history of individual character traits (the genetic method) with a resulting re-orientation in the assessment of their value; and second, the existence of important connections between traits apparently diverse.

What is in some ways a better, and certainly a more orthodox demonstration of the same principle, is afforded by Adler's⁽¹¹⁾ well-known and now somewhat over-worked analysis of the 'Neurotic Constitution.' In this the existence of numerous traits such as ambition, envy, criticism of others, anxiety, and caution, which are commonly found in

neurotic persons, and also in those considered normal, is ingeniously derived from a preponderating 'will-to-power,' which is in more orthodox language the self-assertive 'instinct.' Both the Freudian and Adlerian analyses have the advantage of penetrating beneath the surfaces of things. But the over-simplification of Adler's conceptions and the Freudian generalizations obscure another important point which clinical psychiatric experience clearly demonstrates, namely, the ambiguity of certain traits, taken at their face value. Orderliness will serve as an example. This may be a reaction against a feeling of guilt (as in Freud's anal-erotism), or it may be a compensatory affair as in the methodical people who try to atone for a lack of intellectual ability by extreme carefulness in the preliminaries of work, or it may be one of the manifestations of a temperament habitually anxious, as in the punctuality of certain neurotics (Adler). Similarly, conscientiousness, which is usually regarded in normal psychological questionnaires as a trait having the same value in all normal persons, appears in the light of psychopathology as not at all constant in its significance, sometimes being founded on a feeling of guilt and sometimes being an expression of an anxious attitude to life, rather than a habitual line of action based on higher moral considerations.

7. THE BIOGRAPHICAL METHOD AND ITS CONTROLS.

With precedence over the question of the significance of traits is the problem of the most satisfactory manner for detecting their presence. Some of them can, of course, be observed in action at an ordinary interview with special ease in the case of the mentally sick, *e.g.* orderliness and conscientiousness may reach a grotesque pitch in them. But what the psychiatrist, like the normal psychologist, desires in estimating the temperament and character of any patient is not merely the condition at the interview but a picture of the patient as he was before the development of outspoken 'symptoms' (which may simply be exaggerations of traits habitual to the individual). To obtain this picture in as complete detail as possible, two complementary methods are used—the taking of a careful history and the specific questionnaire pointing to isolated traits; and of these the first is by far the more valuable. In so far as the second has any value, it is simply a rapid method of isolating certain data obtainable at greater length by the first. The taking of a clinical history means simply that the patient describes at length the way in which he has previously met the tests, small or great, submitted to him by his environment. By the manner in which he dealt with them, his

'idiosyncrasy' is judged, and individual traits are isolated. Thus it may be found that he has always faced his problems squarely, or that he has tended to evade them by shelving them for the time being, or by avoiding them altogether by a subterfuge in the form of a neurotic symptom (12). The individual under investigation may turn out to have been habitually timid, in small ways, among his school fellows, or when alone, or in face of physical danger at games. Fewness of friendships, shyness in company, when they can be traced in the patient's history, will often give clues to defects of temperament and character which are not only uncomfortable handicaps but may have a considerable share in producing a mental illness. Such points, of which these are only a few examples, emerge in the course of any history given by a patient, and can be multiplied by directing his attention along certain lines, if his spontaneous utterance does not include them. A record of the personality-in-action of this kind does not take long to obtain, although naturally the more numerous the interviews with the patient and the more his confidence is obtained, the more plentiful and reliable the data become.

It may be asked, How is the veracity of such an account to be assured? There are several safeguards. In the first place, the more a patient talks, the more interviews there are, and the more his behaviour is discussed from a variety of angles, the less likely is he to deceive either himself or the observer. There is a second method of corroboration and of securing additional information—namely, from the friends and relations of the individual under investigation. This is often of considerable value as a check on the patient's account of his habitual reactions; and even the discrepancies can be instructive. Thus, one patient explained that she had always been extremely affectionate and considerate, and she claimed that at a certain crisis in the history of her family she had displayed an ability to sacrifice herself on behalf of the object of her affections that was exceptional. She also felt that she had been most forbearing and self-effacing with regard to her mother. The latter, on the other hand, gave an account of selfish petulance at the time of the crisis; and declared that the forbearance and self-restraint were rooted on no nobler grounds than a grudge. The daughter had always resented her mother's failure to endow her with a prepossessing appearance and with sound physical health. This discrepancy, therefore, furnished an example of a character trait (forbearance) whose determination was quite other than that which would have been supposed on the surface and whose origin lay in an attitude early developed and of which the patient herself said nothing.

Another useful method of interest lies in the 'test situation' furnished by the hospital, if the patient happens to be under treatment there. In a special hospital for such cases, the majority of patients are not kept in bed; hence a considerable social life is possible for them within the precincts. Their behaviour in this social environment can be observed to some extent by the staff, and valuable information is obtainable in this way. It is found that a patient's conduct is sometimes very different in a number of ways from the account of himself which he gives and the impression he creates at therapeutic interviews. Gross discrepancies such as the following are not common. A patient with episodic alcoholic excess who made a show of chivalrously shielding his wife's defects and of an earnest desire to reform his own alcoholic habits, was at the same time found to be generally aggressive, and in his attitude to women patients over-familiar, to the extent finally of a covert promise of marriage with one of them. It is true that there was direct evidence of his emotional instability; but the circumstances mentioned caused it to be estimated as much more grave than the direct evidence from interviews would have suggested. With the object of obtaining such data in a systematic fashion, a list of the more readily discernible characteristics is issued in certain hospitals to the nursing staff, and the latter are requested to record daily, or at less frequent intervals, their impressions of the patients' behaviour in hospital. A simple system of assessing each listed trait numerically is better than noting the mere presence or absence of them.

8. IDIOSYNCRASY AND PROGNOSIS.

It may well be asked what is the practical utility of collecting data by the biographical method and the other confirmatory methods described, in the case of psychotic and psychoneurotic patients. It is still said in some quarters that psychology cannot be considered a science, since prediction is not possible on the basis of formulated laws. In the domain of pathological psychology, it can be said that the outcome of a mental disorder is directly dependent on the pre-existing idiosyncrasy, and that in most cases it is even now possible to predict the outcome largely on the basis of the premorbid traits. Accuracy of prognosis in fact depends more on the careful assessment of the previous personality, than on the nature of the actual symptoms of the mental illness. Given a sufficiently detailed analysis of all the facts bearing upon the outbreak of a mental disturbance, it is possible to make accurate predictions in a very high percentage of cases.

9. EVALUATION OF THE IMPORTANCE OF TRAITS AND THEIR
CATEGORIES BY REFERENCE TO MENTAL ILLNESS.

This brings us to a question which is not less important for normal psychology than for psychopathology. Mental disorder is, broadly speaking, the result of maladaptation to the environment. Except where organic brain disease is responsible for the symptoms, the important factors in the crowning maladaptation that constitutes the mental illness are the traits constituting the idiosyncrasy. Hence it becomes an important task for the psychiatrist to determine what traits have been of importance in leading to the illness, *i.e.* are themselves maladaptive, and complementally, what other characteristics are the marks of a successful adaptation. The psychiatrist is in fact in a peculiarly favourable position for determining the personal attributes that are of practical importance for a successful adaptation to life, since the 'symptoms' are unhealthy (maladaptive) exaggerations of traits often found in normal people, more readily discernible in illness because of their exaggerated prominence in it.

Amsden⁽¹³⁾ has been one of the earliest and most persistent workers in this field, and in his 'personality studies' he has evolved a scheme of categories which he considers to be the most practically useful for psychiatric purposes. First he places the intellectual activities. Second come the 'somatic demands'—physical activity of all kinds, including sexual activity. Under this heading come such topics as the output of energy; whether the patient was inert and sluggish, or active and enterprising; whether and to what extent he indulged in sports and hobbies; whether he was unduly careful of his health; and what kinds of sexual activity were his, and how he regarded them. Amsden's third group of reactions includes the important topics of self-estimate and self-criticism—the attitude towards success, the ability to recognize and correct failures, or the absence of such an ability, leading to evasions, self-deception and inefficiency. His fourth category, not very happily named, deals with the 'urgency to adaptation.' In this he is concerned with the ambition, courage, tenacity, and the like of the individual.

His conclusions in any particular case are arrived at by what has been described above as the biographical method, reinforced with a questionnaire, which, however, he conceives should be used less as a formulary of questions than as an index of the topics to be taken up during conversations with the patient and his relations. These topics are too numerous to tabulate here. They furnish the detail for the categories described above.

What is particularly clear from the study of Amsden's and other psychiatric schemes of personality study, is the divergence from the categories accepted among psychologists of the normal. Not much is apparent of McDougall's schematization of the instincts and their hypothetically related emotional dispositions. Instead of an inquiry founded upon such a theoretical subdivision into the 'instinct of pugnacity and the emotion of anger,' the 'instinct of self-assertion and the emotion of elation' and so on, the psychiatrist resorts first to direct observation of the clinical material at his disposal, and then makes his inductive generalizations on this basis alone. His generalizations have consequently a much closer conformity with facts of observation and with practical needs, than would be possible if he based his inquiries on preconceived formulations derived from psychological theory. The importance conferred upon 'pugnacity and the emotion of anger' by its categorical isolation on a parity with other affective tendencies, and the non-particularization of sexual tendencies evidenced by awarding a mark, *e.g.* + 1 or + 2, for 'sex' in general—both of which methodological curiosities have appeared in reputable studies in normal psychology—are a little ludicrous to those accustomed to deal in psychopathology. The same kind of error leads to the all-too-simple and utterly inadequate hypothesis of McDougall (14), in which he seeks to regard schizophrenia as a kind of fixed and exaggerated shyness. Particularization, the emphasis of detail, within such a complicated group of reactions as is covered by the term 'sex,' and the avoidance of a facile slurring-over, such as can so readily come about in trying to fit facts into theoretically derived schemata, is one of the lessons to be learned from psychiatric personality-studies. Especially in the domain of sex, a field not readily explorable except under medical auspices, the absurdity of the ordinary generalizing estimates of this many-sided activity becomes apparent; although not even psychiatrists, from a reluctance that they have often had in common with the rest of mankind, have conscientiously collected the objective data that are everywhere to their hand. It is unfortunate that only the psycho-analysts have been free from such reluctance, so that now it is very difficult to collect data untainted, either in the patient's mind or in the investigator's, by the Freudian preconceptions.

10. RELATION OF TRAITS AND GROUPS OF TRAITS (PERSONALITY TYPES) TO MENTAL ILLNESS.

It has been found that the study of certain kinds of mental illness enables us to isolate with greater certainty characteristics that are

especially significant for adaptive purposes; and from traits isolated in this way, psychiatrists have attempted from time to time to draw up more or less comprehensive schemes of character types. The former exercise—that of correlating certain idiosyncratic types with certain forms of mental illness—is practically much more helpful, as well as having a much closer relation to observational data, than the attempt to make an exhaustive schematizing catalogue of all possible types, which at present results in nothing but bewildering dichotomies whose useless artificiality has only to be brought into contact with clinical material to be realized. In the former type of investigation, Adolf Meyer and Bleuler produced suggestive and valuable data from a study of the premorbid characteristics in patients who ended in a precocious dementia (dementia praecox, schizophrenic dementia). Their work has the merit of keeping close to the clinical data. Other writers, like Jung, Ewald, Klages, and Kronfeld, the first three with descriptive elaborations, the last with exhaustive interpretative formulae, have divagated into philosophical systematizations which have little practical utility.

Meyer's⁽¹²⁾ researches have shown that there is a significant connection between certain traits and the development of certain abnormal mental states. For example, he has found that in the history of a large proportion of persons developing schizophrenic reactions (dementia praecox conditions) are found such marks of inadequate adaptation as seclusiveness, lack of objective interest, excessive day-dreaming, feelings of inferiority or actual antagonism in the environment, hypersensitiveness to criticism, and so on. The 'disease' consists in an exaggeration of such traits, being simply the end result of their progressive accentuation. The importance of the observation of them lies partly in the bearing they have on the recognition of the practically important factors of idiosyncrasy. Similarly, Bleuler has described such traits as 'schizoid,' while the contrasting personality type he calls 'syntonic.' The conception of a 'syntonic' type is likewise obtained from a study of the abnormal, in this case manic-depressive psychoses. The important elements of the syntonic temperament (Kretschmer's⁽¹⁶⁾ cyclothymic) are the tendency to variations of mood from elation to depression; the close correspondence of mood with type of activity—over-activity going with elation, subnormal activity with depression; the adequacy, smoothness, and naturalness of the reactions in general; and the rapidity of the adjustment to the environment—all contrasting more or less with the schizoid type. It will be seen that in describing the syntonic traits, emphasis is laid as much on the way in which they are knit and work

together, as on the traits themselves. In the syntonie temperament, given the prevailing mood at any moment, many of the other attributes can be deduced directly from it. This co-ordination is itself an important fact in normal conditions, but its significance was emphasized by the study of the syntonie or cyclothymic temperament in the exaggerated phases of the latter, known as manic-depressive insanity. Although co-ordination is a hypothetical entity, standing for the working together of certain traits, it is as weighty a factor in assuring the successful adaptation of a given individual as any of the traits which it is assumed to harmonize.

11. INTEGRATION.

There is another form of inter-relationship between traits, which is even more important than their harmonious co-ordination in activity. From neurology on the one hand and anthropology on the other, psychiatrists have formed the conception of 'levels' of mental function—the total personality ('idiosyncrasy') is the functional integration of a hierarchy of personality-constituents. These constituents are at the lowest level the structural (anatomical), at the next level the physiological (itself a complex set of levels, of vegetative-hormonic and cerebrospinal reflexes); and the third and highest is the psychological or psychobiological, in the working of which the first two are implicit. The distinctive factor in the working of the highest level is the symbolizing function (thought and speech). No opposition of body and mind arises in this conception. "While there is a logical-factual or conceptional-factual parallelism in all these events and spheres, we refuse to put any emphasis on a psychophysical parallelism. We form our verbal (*i.e.* logical) concepts in physics and chemistry and biology exactly in the same way as in psychobiology, and our introspectional data we experience like any other experience. We consider all the psychobiological functions to be functions of the organism, bound to influence and to be influenced by the other functions of the organism, but interwoven according to the principles of integration, not of mere summation. We therefore do not speak of body plus mind, but of the organism in mental attitudes, actions and reactions." (Meyer.)

With a conception such as this, the tabulation of traits and their quantitative evaluation counts for little, unless their organization be also taken into account. It has also followed that not merely the strictly mental characteristics are considered in estimating character and temperament, but that the physical (physiological and anatomical)

attributes are examined, as well as the mental effects of any physical anomalies that may exist. On the last mentioned topic, Adler's⁽¹⁷⁾ work on organic defects and their relation to feelings of inferiority is a well-known but very one-sided contribution. Another aspect of the same biological trend appears in the work especially of Kretschmer⁽¹⁵⁾ on the relation between physical constitution and type of personality. This work is however at present neither statistically impressive nor clinically very helpful.

The conception of levels in the idiosyncratic constitution has received support from other directions. It is considered by some that there is not only an individual but a racial aspect of the concept of levels, the mental level itself being compounded of strata derived from more primitive experience and capable of more primitive forms of expression than that of the highest integration. Clinically, one sees patients behaving in a way that may be looked upon as a return to a more primitive type of behaviour. Sometimes it is primitive simply in the sense of resembling the behaviour that might be expected of an infant (regression). In other instances, there are attitudes and utterances that can be closely paralleled by what is found among so-called primitive races. Storch⁽¹⁸⁾ adduces a number of interesting examples. Some writers (e.g. Kretschmer⁽¹⁶⁾) have seen in hysterical dream states, and motor disorders, analogies to primitive states of consciousness and of volition. In the delusions of other patients, the affective projection involved is compared with that investment of natural objects with awe which is seen in primitive religions. The material gleaned from dreams resembles a more primitive type of thinking than the ordinary in two ways: its form is more exclusively visual, and the apparent symbolizations are reminiscent of the figures of mythology (Jung, Freud).

The highest form of social adaptation, the greatest efficiency, involves the harmonious co-operation of all the levels of activity to produce the perfectly adjusted idiosyncrasy. If any of the more primitive activities obtrudes itself upon the integrated activity, then to that extent the integration and the adjustment are faulty, and a character defect or 'symptom' is produced. Evidences of so-called 'nervousness' in the history of an individual become, in this light, defects of temperament and character no less to be taken into account than any other trait.

12. INHERITANCE AND CLEARER DEFINITION OF TRAITS.

In studying integration of whatever kind, it is very desirable to be able to know the units of which the integration is compounded. In the

anatomical and physiological field this is perhaps not so difficult as in the psychological, where definable units can hardly be said anywhere to exist. With the hope of isolating such unitary elements of character and temperament, attempts are made to trace the inheritance of such traits, especially by tracing them among the ascendants of persons in whom they are accentuated to form a mental disorder. "The significance for character-analysis of the investigation of hereditary characteristics lies in the help that may in course of time be obtained in discerning psychic elements or categories which shall have a biological independence." (Hoffmann⁽¹⁹⁾.) "It will be a matter of anlage-elements inherited independently of each other." Hoffmann claims some success in this attempt, showing how inherited traits change in importance in successive generations, in the ascendants occupying the foreground, in the descendants receding, being still present, but yielding in prominence and importance to others, and so sometimes determining the change of a family's fortunes. It is another example of the importance of considering each trait in its setting—in its relation to other traits in the idiosyncrasy. He emphasizes also the importance of the environment for the appearance of certain characteristics, which sometimes lie latent in one generation for lack of opportunity, but appear prominently in the next. Changes of character may occur also within the life-time of the same individual, for a similar reason. The best-substantiated of Hoffmann's deductions from his study of the inheritance of character and temperament are, therefore, confirmatory of what has been obtained from the study of the individual; but if the method helps (as Hoffmann claims it will) to establish a "systematic conception of character-formation which will serve as a control for our empirical material," then our estimates and predictions, both for the adaptive success of 'normal' personalities and for the outcome of mental illnesses, will be much better founded than at present.

13. SUMMARY.

1. 'Idiosyncrasy' is suggested as etymologically a very desirable substitute for 'personality' to connote the integration of traits of temperament and character in the individual.

2. Clinical experience in the direct observations of affective abnormalities affords no very useful hints for the detection and estimation of emotional states actually present. On the contrary, it seems rather to emphasize the complexity of the conditions involved. It follows that mere impressions gleaned at an interview may be very misleading. This emphasizes what is found with 'normals'.

3. The usefulness of the conception of a 'general intensity factor' in the emotional disposition is at present in doubt.

4. Instruments of precision, recording the physiological accompaniments of pronounced (abnormal) emotional states, are of little practical value in estimating the kind and degree of the emotional state present.

5. The only satisfactory method of estimating temperament and character is the biographical one (history-taking) checked by accounts from the patient's relatives and friends, and by observation if possible under social conditions of a restricted kind, *e.g.* in hospital.

6. Traits should not be taken at their face value, but should be as far as possible traced to the sources; and their relationship to other traits and to the total idiosyncrasy, *i.e.* their 'setting' should be considered. This is what is meant by the 'genetic-dynamic' analysis of traits.

7. A mental illness is broadly the result of maladjustment of the individual to his environment. It frequently consists in the exaggeration of certain traits of temperament and character which existed in the individual before he became recognizably 'ill.' These traits are therefore maladaptive and increasingly so. Hence from the study of mental illness, the relative importance of certain traits for successful adaptation can be ascertained. The emphasis which comes to lie on certain traits and groups of traits is in some respects different from the values deduced from the theoretical considerations of normal psychology. There is some correspondence of certain groups of traits and types of mental illness. The prognosis of the latter depends as much on the pre-existing 'idiosyncrasy' as on the type of illness that develops, some pathological exaggerations of traits being reversible, and others not.

8. The manner of integration of traits in the total idiosyncrasy is of special importance both in normal and pathological psychology.

9. The study of inheritance may lead to a clearer definition of unitary traits.

10. A considerable change in idiosyncrasy may appear at one time or another in the course of the individual's life, the change being determined sometimes by endogenous (or even inherited) factors; and sometimes by a change in the environmental stimuli. Idiosyncratic, like physical, development may be accelerated or retarded by environmental influences, of which the family is the earliest and probably the most important.

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THE MENTAL HYGIENE OF THE PRE-SCHOOL CHILD¹.

By SUSAN S. ISAACS.

It will, I suppose, be agreed that no subject of greater psychological interest or practical importance could come before this Society than that of mental hygiene in the little child. As with disease in general, attention has within the last few years shifted from the problem of cure to that of prevention; and this has come to mean, here perhaps more than anywhere, a corresponding shift of interest from the adult to the child, and from the child to the infant. Whether as doctors, social observers or educators, all those who have any concern with the neurotic adult, or with any disturbances of conduct and mental health in youth or manhood, are now developing an interest in the early disposing factors, and possible ways of dealing with these. The intelligent parent is asking for advice as to what he should do to avoid neurosis—if there be anything *to* be done; and here and there he meets with those who speak with no uncertain voice as to what should be done and what should be left undone. Others of us who have had opportunities of studying both neurotic and normal children at close hand over a long period, and in the light of some knowledge of their parents' minds and home conditions, are more sensible of the obscurities of the problem, and of the difficulties of laying down any broad body of clear and definite principles of certain prophylaxis, in the present state of our knowledge. We know much, but by no means all, nor with complete certainty.

I should like to consider some of the difficulties in the way of setting out clear lines of advice for the prevention of neurosis—whether to this or that parent, or as general social and educational doctrine, bearing on the mental hygiene of the pre-school child.

If, then, we have come to look for the point of origin of neurosis in early childhood, the first question clearly is how to know the neurotic child, or the neurotic-child-to-be, when we see him.

In many cases that is, of course, easy enough. If a child of, say,

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five or six years has persistent night-terrors, or enuresis; if he masturbates constantly; if he is patently and continually destructive and defiant, stealing, biting, behaving with marked cruelty to younger children; if he is excessively clinging and querulous, if he shows overt anxieties and phobias, or marked speech disturbances such as stammering or refusal to try to talk at a late age—in any of these situations it is easy enough to affix the label of neurotic. The physician will do it at once, and nowadays many a well-informed parent is able to. But it will, I think, be agreed that in these very cases it is hardly any longer a matter of prophylaxis, but already one of well-developed neurosis. If one approaches the problem in a stereotyped way from the point of view of the grown-up, then of course anything that happens in the years under six might be held to be an 'early' stage of development and disease; and anything that is done to alleviate matters might be considered prophylactic. But that is to give a naïve value to the mere passage of time which it does not deserve. All our knowledge of genetic psychology in general, and of the nature of neurosis in particular, runs counter to such a view. The analysis of adults shows that the pattern of their responses was already firm by the end of the period we are considering, the rest of their development being very largely an embroidery around the original theme. But particularly is this true of the neurotic, since a certain fixity of response, a way of forcing all later experience into the mould of the earlier, is one of the essential characters of neurosis. Young as the child may be in years, the psychology of the neurosis compels us to regard such manifest difficulties as those mentioned as signs of definite and matured neurosis; and the problem in these cases as already one of cure, not prevention.

For preventive mental hygiene, our signs must needs be more delicate, and earlier seen.

Unfortunately, we have so far hardly any comparative data upon which to go, since the child is not, except in the rarest instances, brought to the physician or the psychologist in the very early stages, while the neurosis can be looked upon as incipient. Clearly, if a child of two or three years is seen by ordinary, unspecialized parents to be even a little abnormal, then it is ill indeed. The psychologist, it is true, can make his opportunities of watching ordinary infants and young children; and since, very fortunately, there have been a few parents who have brought their 'normal' children for observation or analysis on purely prophylactic grounds, the experienced observer has learnt to read the signs to some extent. It needs, however, a very sensitive perception to recognize

the neurotic child in the earliest stages. The inherent difficulties are clearly far greater than in the case of the grown-up, since many things that would mark serious illness in the case of the adult are entirely normal in the young child. It is, for instance, quite normal for the young infant to cry and shout angrily when he cannot get what he wants, to fear the unknown, to empty his bladder and bowels when it pleases him, to depend helplessly upon his mother's love and care. These are the characters of the instinctual life of infancy, and are found in every child, whether or not he becomes neurotic. The problem for us is to know how to distinguish at this early age between, for example, neurotic anxiety and the fear normal to infancy; or, again, between neurotic defiance, hiding deep anxiety, and healthy self-assertion. To know in general that it is a matter of how much and at what age, or of the appropriateness, intensity and fixity of emotion, is one thing; to be able to read the situation precisely in any given case, is another. In the highly intensive and sustained observation afforded by the actual analysis of a child, the diagnosis may be clear enough; but apart from this, and from the cultivated perceptions which such experience brings, I suggest that the reading of the less obvious and dramatic signs of ordinary life is far from easy. Clearly there will always be a general tendency to overlook the earliest indications and to under-estimate their seriousness.

But let us go on to another difficulty, one of perhaps even wider practical import; and that is, that many of the ways of behaviour in a very young child which would at once suggest the possibility or even the certainty of neurosis to the more experienced observer are actually welcomed by the parent and educator as signs of moral development, or chuckled over as evidences of childish quaintness and precocity. A pleasing docility, the absence of open defiance and hostility, particular tidiness, a precise care in folding and arranging the clothes at bed-time, careful effort not to spill water when drinking or washing, anxious dislike of soiled hands or mouth or clothing, solicitude for the return and safety of the mother or the younger child, meticulous kindness and sensitive dislike of cruelty to other children or pet animals, ritual attention to the saying of prayers, frequent endearments and shows of affection, waiting always until one is spoken to before speaking; the offering of gifts to older and stronger children, an ardent desire to be good or clever, an intense ambition not to have to be helped, docility to punishment, drawing-room politeness, the quiet voice and controlled movements—most of these things either please or amuse the parent. Yet

any one of them, and particularly several of them found together, may be and often are effects of a deep neurotic guilt and anxiety. The textbooks have, of course, long been telling the educator that he must beware of 'excessively' good behaviour; the parent who has read anything at all about recent psychology has heard of reaction-formations, and so on. But how is anyone, other than a pure psychologist, and one trained in the study of the neuroses, to know when goodness begins to be excessive, to notice in time that the child is adapting himself only too dangerously well to his 'life-task,' and the demands of adult values? Above all, how is a parent or educator, whose job is to bring about that very adaptation, to be aware of the deep suffering which may be hidden behind the fair exterior of the good child?

Let me describe a few examples. Among a group of little children which I have recently had the opportunity of observing, under special research conditions, was a charming boy of four years of age, an only child, of not too robust physical health. As was not very surprising, he was at first shy and timid, on being plunged into the group of ten or twelve very vigorous and lively boys running and shouting freely, and sat very quietly watching. Soon, however, he found his feet, and ran and shouted freely with the others, showing, as time went on, increasing initiative and enterprise. He was essentially a good and tractable child, never showing hostility or defiance. There was no trace of priggishness about him, however, and he was very far from being *the* 'good child' of the caricature. He was, in fact, distinguished by a robust and delightful sense of humour—he would play at being defiant with the most attractive roguish laughter. Laughter was, indeed, at this stage, the main outlet for his anxieties. For example, he invented a humorous game when using clay, which he very much enjoyed. He pretended that his thumb-nail was coming off, putting a piece of clay on his thumb, and pulling it off, with hearty and infectious laughter. He had, however, before coming to school, shown two symptoms of neurotic anxiety—occasional frightening dreams which woke him up, and nail-biting. Apart from the nail-biting, his governess had no difficulty in keeping him up to her strict standards of behaviour, and, at home as at school, he was a pleasant and amenable child. After a time, under the freer conditions of the group, his nail-biting almost disappeared, never occurring in school—where, indeed, he now stood out among the other children as an unusually well-adapted child, with a free and vigorous mental life, and great aptitude for happy and constructive play. Yet after a year of apparently most satisfactory intellectual and emotional

development, a well-marked neurosis rather suddenly appeared in the shape of constant and severe stammering, and distressing attacks of overt anxiety if he accidentally broke anything, whether his own or another's. He broke a plate at school, for instance, and was overcome by a terrible storm of anxious weeping which no words of comfort could help; and on slightly damaging his own gramophone, refused to touch or look at it again. Fortunately in this case the parents were informed people, and arranged for an analysis. This revealed a deep and severe neurosis, successfully hidden under this fair façade of charm and adaptability, and precipitated by the very freedom on which he had seemed to thrive so gratifyingly. In other words, he had been a good child because his need for punishment for his unconscious libidinal wishes was so great; and when he did not get the censure and strict demands for which he craved, the pressure of the underlying neurosis broke out in unmistakable symptoms. His analyst confirms my impression that any situation of great choice or responsibility in later life, or any circumstances in which free gratification of desire became possible, would have been likely to precipitate the neurosis in this way.

Take another case. A boy of three and a half urinates in his trousers in circumstances which would lead *us* to make every excuse for him, and is overcome by the most heart-rending shame and bitter distress, a shame the intensity of which would again spell neurosis to the experienced student. Yet how difficult for the ordinary parent to see that it is not so much the fact of the 'accident' in these circumstances which needs his attention, as the distress which follows it! How can he do other than feel pleased that the child is ashamed of himself?

Another boy of three falls down and hurts his knee; after brief tears, no one being close at hand, he is heard to say reflectively, "Why should I cry?" The father reports this with pride and pleasure, feeling it to be commendable good sense and a delightful precocity. But a more skilled observer would see in such a reaction at this age an alarming detachment that hinted not merely at a high intelligence but also at an overwhelmingly powerful super-ego, with neurosis as perhaps not the worst evil in the future. And he would have been right. For the same child at five and a half and six years of age shows periods of unusually successful social adjustment and charm, alternating with phases of markedly regressive querulousness of an oral type, and inability to bear thwarting, the whole pattern being woven on a deep underlying melancholy. And the detachment persists, with a devastating self-knowledge and self-criticism. At five and a quarter years, the boy was staying

away from home, and showed a continual and unsatisfiable hunger. After he had asked for apples over and over again, someone said to him laughingly, "You are very hungry, John!" "Yes," he replied, "I don't like this house, and that's why I'm always hungry." Or, in our words, his being sent away from home to a strange house, away from the warm and comforting presence of his mother, re-awakened the earliest deprivation of all, the loss of the nipple and the resulting oral dissatisfactions. His penetrating remark revealed the strength of the oral fixation, and the extent to which all later experiences would be assimilated to its absolute pattern, with consequent difficulties in the acceptance of loss. Out of the mouth of this babe and suckling came forth wisdom indeed. And at six, on having *Hiawatha* read to him, he asked, "Why was *Hiawatha's* father an unkind man?" Presently supplying his own answer—"I expect he was unkind because he didn't like himself; because he didn't like himself, he didn't like other people!" Again the parents quote his remarks as interesting and delightful evidences of his high intelligence—as indeed they are; but of such a kind as to make any student of the individual history of neurosis watch his development with anxious interest.

Another type of behaviour in the pre-school child which naturally delights most parents, but which some of us would watch very closely as a possible hint of the inner tension which may later on issue in positive neurosis, is the intense desire to model himself upon the parent which leads to precocious learning to read and write. One would at any rate attach importance to this if it were accompanied by any inhibition of pleasure in play and in the expression of fantasy. Again I have definite cases in mind. A boy of barely five, for example, who cannot be persuaded to try modelling in clay because it makes his hands dirty, but who can already read and write up to the normal level of a school child of seven—we are not altogether surprized to find presently that he cannot play happily with a group of children, but must needs torment them into turning on him and making him take a whining refuge with a grown-up, whose hands he clings to convulsively, and only leaves in order to make a furtive attack on the others again, returning at once with a cry of masochistic terror to the protecting adult. The parents are angry when he cries instead of defending himself, and naturally disapprove of his sly attacks on others, treating these things, of course, by moral exhortations; but the precocious reading and writing, and dislike of getting his hands dirty are welcomed and admired. Yet these latter are part of the same psychological picture, and to be also regarded

as neurotic symptoms. Sometimes, indeed, the precocity of intellectual development and intense intellectual ambition are the only positive indications of a neurotic diathesis, although they are more safely to be looked upon as such when set amidst a general inhibition of play and fantasy. The child of four and five years who looks on with a bored expression while others romp about pretending to be engines and trains (with his parents again pleased that he is beyond such infantile games); the girl who will not have a birthday party when she is five 'because grown-ups don't,' and who at two years of age insisted on trying to do everything in the way of climbing or jumping that children several years older were doing, crying out with urgent and shrill anxiety if one went near her—"Don't hold me, don't hold me!" These are spiritual ambitions which I should again watch with some misgivings.

One knows, in all these cases, from the details of analysis that the intense ambition involved points to the severest type of super-ego; and the fact that it has taken a direction which is, on the surface, socially desirable and consonant with adaptation to reality does not compensate for its intensity and despotism. One knows, further, that such intensity indicates that the desire for knowledge and intellectual power is still too strongly libidinised, and itself but a mode of flight from unconscious libidinal wishes, and is therefore liable, at any time of real stress, to suffer from the inroads of guilt. And such a theoretical forecast is amply confirmed from the observation and analysis of adults. Such over-ambitious persons are amongst those who, at the best, are liable in times of severe stress and crisis to attacks of insomnia and depression leading to a 'breakdown' which defeats their ends and renders their real abilities nugatory.

These, then, are some of the difficulties in the way of the parents' recognition of the earliest signs of neurosis in the pre-school child. Such signs tend to be overlooked either because, on the one hand, they seem to belong to the normal instinctual characteristics of the young child, or because, on the other, they masquerade as welcome signs of growing intelligence and moral development. One might in passing add the further difficulty that the majority of parents would far rather put the trouble down to moral lapses and original sin, even in the case of quite severe neurosis, than admit that a child is in any degree emotionally disturbed—or, as one parent put it—'*mental*.' This springs, of course, from the universal and deep anxiety which makes all ordinary people regard insanity with horror. Like the other difficulties mentioned, it is of importance because, from the nature of the case, the question of the

early diagnosis of the neurotic child is necessarily so much in the hands of the parent. Unless and until such time as we have found some way of conveying to the parent and educator the refinements of our own perception of the earliest symptoms of neurosis, our work can hardly be in fact prophylactic.

I have emphasized these difficulties, however, not only because they are relevant to early diagnosis in any particular child, but also because they bear so intimately upon the question of etiology, and, therefore, of practical conclusions. We now know a good deal about the inner conditions of neurosis, and we know something about the external factors. The No Man's Land of comparative ignorance is the exact relation between the inner and outer factors ("between the fixations and the way and the time at which those fixations become connected with experiences," as Mrs Klein has put it). It might, I think, be said that some of those psychologists who have at this date most confidence in offering prophylactic advice to the educator are the ones who lay most weight upon the external precipitating factors. They emphasize either the simple traumatic theory, in which a shock of some kind is held responsible for the neurosis—an attack by an animal, a threat of castration, a seduction, an actual viewing of parental coitus, the infant's being half-suffocated by the large pendulous breast of a careless mother, and so on; or the same theory in a more veiled form, in which the general behaviour and characteristics of the parents, their day-to-day words and moods and actions, are held to be the effective cause. It is, of course, true that these external factors are the only ones we can alter, or most readily alter; and optimism naturally turns its gaze in their direction. Yet until we have more understanding of the precise interplay of inner fixation and actual experience, where the crux lies, optimism must needs be curbed. And for this understanding, we need the most precise and intensive knowledge of both inner tendency and outer circumstance. It seems to me that it may be theoretically very misleading to base any possible principles of prophylaxis on merely *extensive* data, on a surface comparison of cases showing well-developed symptoms; and that comparative data of an intensive kind, based upon the earliest possible diagnosis, and upon the detailed observation afforded by actual analysis, are indispensable. For these reasons I have ventured to emphasize, as a first consideration, the practical difficulties in the way of early diagnosis.

THE RÔLE OF ORGAN INFERIORITY IN CON- STELLATING A CASTRATION COMPLEX.

By P. LIONEL GOITEIN.

IN the course of an analysis of an incipient psychotic—interesting to science from many other standpoints—we came across an hereditary stigma that seems to have played some small part in the fabric of the disease, and which from its novelty and interest we consider worthy of record.

The patient displayed for the most part symptoms in no way referable to the specific complex under discussion, and a psychopathology scarcely attributable to the somatic deficiency in question; but lighting upon it by accident we felt it might pardonably and fairly exemplify an Adlerian mechanism, and this short note will limit itself to the re-synthesized material immediately related thereto.

Our patient twenty-one years of age recently graduated with honours in arts; and after a very successful career at school and university broke down dramatically. His (manifest) breakdown coincided with the last day of his examination and the return of his (divorced) mother, and his intending launch-forth at last on an independent professional career. He became a wholly dissociated personality, whose dominant feature was the discovery of apparent unreality in everything and an unfamiliarity with his entire environment. Everything changed over. We discovered among other things that he believed his vermiform appendix was now on the left side, and he pointed vaguely to the situation. It had previously been removed, and a scar was visible on the right, but he was satisfied that it had grown again. It transpired in the course of investigation that he was embittered against the surgeon (who represented the father) for removing this appendage, and 'cutting it off,' as he said, from that region of his anatomy. So in phantasy he allowed it to grow again, but on the opposite side. The appendix signified for him, we found, the male appendage; and the original operation, performed when he was nine years of age, made its indelible imprint on his sensitive mind, as an actual, or talion, castration. He had been masturbating unknown to anyone from the age of six, and on and off almost to the present time, a few weeks before his tripos, which again caused him to desist. Just as the original operation (*de complaisance*) signified to his

Unconscious his father's punishment on him for his sins, when the urge came back again in the midst of the strain of examinations and he gave way (indeed the emergence of the psychosis may have precipitated the release of the inhibition), once again the talion punishment appeared, and he compromised by sacrificing the 'phallus' of the right, and creating a new one on the left—the psychosis being such that "re-creation by imagination" was the dominant theme. A visit to the dentist a short while before and the use of 'gas' probably served to remind him of a similar gas (chloroform) at the earlier operation, and the extraction of a tooth was similarly productive of the old resistance to castration. Indeed he struggled violently (unconsciously), so that the crown broke off in the attempt, the fangs still lying embedded in the jaw.

A further motive for the focusing of the Unconscious upon the appendix was a wish to be like a younger and dearly-loved brother (i.e. dead); for the patient, on admission, imagined himself dead but ready, it appeared, to rise resurrected. Now it transpired that this brother, to whom he had homo-sexual attachment, died of an acute appendix; indeed he showed symptoms at the age of nine and a half years, about the *same time* as his brother, the patient. Both were examined by the surgeon together—this being the first time the patient had been medically examined, and stripped naked for the purpose, a procedure he invariably hates. The surgeon, despite the symptoms, refused to operate on the brother, but did so very soon on our patient. He was cured; the brother, however, not long after developed a second attack and died before an operation could be performed. The impression was intense; the loss and the circumstance saddened the patient at the time, and there can be little doubt that the present castration-fears and death-desires are directly related to the original wish. The wish is to be like the brother in (psychic) death, with his penis (appendage) unre-moved, or at least re-creating a new one in revenge on the father. From brother he now turned to his mother for erotic anchorage. The subsequent powerful maternal-fixation (certainly evident in the psychosis to-day) gives evidence further of this hatred of the one and this desire for the other, the two ever in conflict. Delusions are prominent, and once again the dominant delusion in the fabric of his disease is a fear that chloroform (or gas) is being sprayed into the room by unknown hands.

So far then, the appendix had provided the *point d'appui* for that constellation of ideas which determined the bent of this particular phantasy. We would, however, go a step farther and see in this very

circumstance, this dramatic development of appendicitis, either a wish for a similar inflammation in the phallus (gonorrhoea; associations with prostitute desires) if we view it on the psychological side; or from the organic standpoint, a somatic weakness in one particular organ focusing involuntary attention upon itself, a vestige never well functioning in the boy, and making its morbid presence felt in the deeper self, the Unconscious. The only weakness in the Adlerian hypothesis on this point is that, in the case of the gut, unlike the voluntary structures and musculature of the body that have sensory and motor connections registering in the cerebrum (for ultimate absorption by the Unconscious), its Auerbach nerve-plexuses have no cerebral registration, are unrepresented in Consciousness; and our only *conscious* knowledge of their working or mal-functioning (or if this be of too insignificant a character, subconscious registration thereof) is by distension pains, *i.e.* stretching of the sensory nerves of the peritoneum. This is productive of referred pain in the segmental distribution peculiar to that level, and in this way traceable *via* ascending sensory paths to cerebrum and so to consciousness. Possibly this is what Adler implies; there exists in all such cases a vague focus of attention on the *segmental* area co-related to the viscus affected; and the patient in pointing vaguely to his iliac area signifies *appendix*; just as hysterics pointing to the lower abdomen with hypochondriacal feelings would, on Adler's hypothesis, be revealing 'areas of reference' from an organically inferior *ovary*.

The case under discussion indubitably had an affected appendix which, from the nature of his heredity, *did* seem to be organically predisposed, organically weak from birth; and so the mind, the Unconscious, was weaker on this point (if we might be allowed to use the metaphor) in consequence. We have sufficient evidence of familial weakness in regard to this, *e.g.* the coincident appendicitis of his brother, and when we add that his maternal uncle had a severe attack of appendicitis, another was operated on for appendicitis, and even his mother had operative removal following an attack, we think there can be little doubt that he was organically weak and inferior in this organ. How far it in itself determined the delusional phantasy, we cannot say; there were many more potent factors, not the least being the identification with the brother, the love-object and mirror of himself at first; self-accusation and condemnation (projected on to the father) for self-abuse, further narcissism, the death-wish, and re-creation of the phallus by taking thought. Then there was an actual identification with his mother, certainly as regards the appendix. Extensive evidence existed

for this; he was 'feminine' on admission, so that he could "give birth to himself" as he owned, out of his own maternal womb. It is true that this identification may cover a wish to be 'one with' her, *i.e.* on a par with her and no less 'one with' her, united with her, and that the castration complex is, in small part, retaliation for incest wishes.

In any case, the one delusional idea was but a stone in the corner of the psychosis that the phantasy-builder had rejected, but which we would reclaim; for the one point upon which we think we may rightly lay stress (to the exclusion of other and extraneous psychological material) is, that an inherited organic inferiority has succeeded, in part, in producing the castration-complex of at least one analysed case.

THE BASIS OF GROUP-ANALYSIS, OR THE ANALYSIS OF THE REACTIONS OF NORMAL AND NEUROTIC INDIVIDUALS¹.

BY TRIGANT BURROW

MENTAL disorder is an industrial problem—a problem in how to get along. It is also an organic physiological problem—a problem in biological economy. The biological economy of an organism is the functional integrity of its parts. Mental conflict and insanity, industrial conflict and crime are disorders of economy or of adaptation that lie within us as integral parts, not outside of us as detached onlookers. They present problems not of ourselves as isolated individuals, but of ourselves as a community. They are problems in community living, in how to get along with others. These problems are physiological and economic, biological and social.

Group or social analysis is the analysis of the immediate group in the immediate moment. A social group or community consists of persons each of whom is represented under the symbol he calls 'I' or 'I, myself.' This proprietary symbol is socially accepted by the individuals of the group. It is the basis of their intercommunication. But the 'I' that is socially accepted is socially elusive of analysis. The group composed of individual 'I's' is equally elusive of social analysis. The sum of impressions symbolized as 'I' would centre attention everywhere else than upon the sum of impressions thus symbolized. Group-analysis is the objective analysis of this subjective symbol as represented in the immediate group in the immediate moment.

We have long grown familiar with the dual expressions of our neurotic patients, with their manifest or apparent content in contrast

¹ Paper read on the occasion of the Fifteenth Anniversary of the Phipps Psychiatric Clinic, Johns Hopkins Hospital, April 30th, 1928.

Naturally a paper having to do with the adaptation of groups or communities as it bears upon the interreactions of individuals as social integers suggests at once those factors of integration which Dr Meyer has for so long emphasized. This position is one with which Dr Meyer has for a period of more than twenty years so fully identified himself that it is a familiar theme to those of us who have been associated with the Phipps Clinic and with his fundamental conceptions. My only excuse for returning to these factors on this occasion is the circumstance that for several years I have, in association with others, been daily occupied with the practical observation of these interreactions as they are found to occur under the experimental conditions of actual group setting.

with their latent or repressed content as represented in dreams, in symptoms and even in casual discourse. The group method of analysis has endeavoured to apply the same analytic principle to the manifestations of our casual social interchange and to discover in each expression of current social usage both the manifest and the latent content, the apparent and the repressed meaning. A statement is not taken upon its face value, but is subjected to the test of analysis in order to discover whatever unacknowledged content may be included in the overt expression. Where ordinarily an expression is accepted as quite *bona fide*, we now look for whatever reaction may run parallel to and beneath this manifest statement. No expression is considered complete in its surface aspect or content. But observation is directed toward whatever undisclosed proprietary motives may exist in contradistinction to our avowed statements.

The number of persons composing a group-session has come to be limited, empirically, to about ten. As now arranged, the sessions are held once weekly and continue for one hour. The object of the group-analysis is to give to the individual the opportunity to express himself in a social setting without the inhibitions of customary social images. By the social image I mean that deflection of attention which shifts the individual's focus of interest upon his awareness of himself in respect to others' awareness of him. I mean the duplicate or self-reflected image that constantly attends him in the mental and social standard he has of himself. This factor of a shift of attention has significance for us as being fundamental in the structure of the latent social content. For it would appear that by virtue of this social or duplicate image each one of us tends to enact a given rôle, to portray a certain character or part in the social scheme of things, and it is the object of the group-technique of analysis to enable the individual to express himself as he is—as he himself thinks and feels when utterly divorced from and unsupported by this social image of himself¹.

In addition to the opportunity afforded each student or patient to give expression to himself apart from his social image or self-reflection, there is the opportunity for him to observe and to demonstrate in other students of the group any expression which may carry with it this latent import of the social image. In this way each student has the opportunity to bring to observation the latent social content discoverable in the manifest content of any other student. In this function he brings

¹ Social Images Versus Reality. *The Journal of Abnormal Psychology and Social Psychology*, xix, No. 3. October-December, 1924.

to evidence latent social tendencies not otherwise brought to observation. In his function toward the social analysis each student, like the psychoanalytic patient in respect to his own symptoms or dreams, discovers latent social reactions in which he must otherwise, like the patient, remain an unconscious proprietary participant.

Upon bringing to light the manifestations of the latent social content, it would seem that these manifestations consist of feelings which would tend to place each individual opposite to and in a relation of transference or moralistic dependence upon every other individual¹. In his latent social manifestations the patient or student appears to be acutely sensitive to the impression he creates upon others. He is at all times at pains to reconcile his impression or image of himself with the image or impression which others entertain in regard to him. This marked deflection of attention toward concerns that are irrelevant to the immediate inquiry, this preoccupation with his appearance or behaviour with respect to those about him is shown to be the outstanding expression of the latent social content.

And so it would appear that a condition of self-consciousness or of preoccupation with this duplicate social image is characteristic of this latent social mood. This acutely self-conscious, moralistic attitude is plainly correlated with the moral feelings of one's early home environment. It makes connection with the earliest impressions of the family and especially of the parent-child relationship. For this fictitious social image is substituted in the childhood of each of us. Each of us is early initiated into this manifest or symbolic content of the social consciousness and under the symbol of the 'I' one's very self becomes a symbol in this manifest social expression. For each of us is made aware of his image or appearance in relation to those about him. Each is made aware of his image in the light of the image others have of him. Our place, our position among others is reckoned wholly in terms of this social image or manifest content, and in the memories of our own childhood we may trace its ancestral descent. As the student becomes more and more skilled in the technique of observation afforded by group-analysis, he is enabled to demonstrate again and again the intervention of this quite irrelevant social image and to indicate its generic place in the latent social content common to the group or community.

Let us take an instance in which a patient or student voices some complaint, offers an opinion or asks a question—instances typical of the

¹ The Problem of the Transference. *The British Journal of Medical Psychology*, vii, Part II, 1927.

manifest social content. The opinion, the complaint or question is not regarded in its apparently direct meaning, not any more than the symptom or dream of a patient, and it does not, therefore, receive a direct answer. Instead, one examines into its latent content, into the elements that may have prompted the question. One looks for whatever is proprietary and irrelevant. Who is the person asking the question? What is his background? Why has he asked this particular question? What will he do with the answer? Why does he direct it to this or that particular person? What is that person's especial relation to him, or what relation would the questioner like to assume toward the person addressed?—I do not mean that the student is literally confronted on every occasion with these specific demands, but they will indicate the general background against which our statements are tested. Perhaps some gesture accompanies the question, some expression of rigidity, a disclosure of uncertainty not implicit in the question itself, a fear perhaps, a suspicion; or there may be some effort of propitiation, some indirect plea for sympathy and anticipation of dependence. Perhaps the question discloses a note of competition or criticism or indicates some irritation. All these and many more such physiological accompaniments and latent intimations are material for analysis. For the repeated observation of the interreactions of individuals in groups indicates that there is never the absence of such accompaniments, and that such accompaniments are never without their conflicting symbols or images in contrast to the manifest content of the spoken word.

This over-evaluation in each individual of the self-image symbolized as 'I,' this image of oneself which one tends to carry about with him, comparing himself with the mental image he carries of others and which others carry of him, is again and again brought to open group-awareness. But always emphasis is upon the common, socially pervasive character of what the individual presumes are quite privately cherished and secretly guarded images. So that the immediate recourse of the isolated individual to elaborations of the self-image called 'I' or 'I, myself' is viewed not as specific to the individual but as generic to the group; and not to any particular group but to the community as a whole. The patient's invariable effort, therefore, to obtain attention upon himself because of what he calls his particular manifestations, clinging to them avariciously as though they were some incommmodity or illness quite private to him, is consistently neutralized by distributing our group attention upon these same conditions as actually demonstrated in the group as a whole.

This feature of group-analysis I should especially like to emphasize. Under no circumstance does the procedure consist in the analysis of the individual by another individual or individuals. Whatever manifestation a student may present, in no circumstance is he made answerable for it as though it were a reaction particular to him. Whatever it may be, the manifestation is viewed as the expression of a latent content that is common to the group as a whole. Under no circumstance is the reaction of anyone regarded as isolated or separate. Nor does the group as a whole mean any particular group as differentiated from another group, but by 'group' is meant the social constellation generally with its ramifications throughout the community at large, the immediate group being but a constituent of this larger unit.

Perhaps the most interesting feature of group-analysis is its tendency to break down certain categorical demarcations in the field of mental pathology, particularly the differentiation between normal and neurotic reactions. As far as our observations have progressed, it would seem that from the basis of the group inquiry there is no difference whatever between the social images of the neurotic and social images as they occur in normal individuals. The origin and mechanism of their development would seem to be identical in both. So that from the position of the group basis of observation, the discrimination between the neurotic and the normal becomes an artificial one. Not only is the normal as completely a prey to the images comprising his latent social content, but he is quite as inaccessible to a rational attitude toward these private images occurring in himself as the neurotic is inaccessible to a rational view of these images as they occur in him. It is repeatedly observed in actual experimentation that individuals who may take a quite objective attitude toward the social images of others are utterly inaccessible to all approach when these same images are operative within themselves. In this lack of insight there is no difference between the reaction of the normal and of the neurotic. This identity between social repression existing in normality and the individual repression observable in the neurotic has naturally led to an altered evaluation of neurotic processes as to an altered technique in the effort to cope with them.

As one attempts to account for this phenomenon of the social image, one is faced with the necessity of very radical modifications of approach. These modifications are in the direction of more generic backgrounds—backgrounds that are not theoretical but actual, not historical but experimental and immediate. Mental disorders come to be seen as the product of racial inadvertences of growth rather than as individual

anomalies¹. As elsewhere in biology, a phylogenetic basis of interpretation becomes essential in correlating ontogenetic findings, and mechanisms illustrative of the inter-social reactions of individuals as a community or race have made imperative a consideration of the origin of man's interreactions as a community or racial organism².

Among the processes which mediate the functioning of the social organism must be included those physiological balances of tension and release which place the individual in conscious relationship to his environment—the process we know as attention. The chief instrument employed by man in the process of attention is the social symbol or image expressed in the spoken word. This instrument or image adopted by the race serves as sign or token of a common content of meaning. In this common meaning there is comprised the manifest content of the social consciousness.

In the evolution of man, however, and in his emergence toward higher processes of integration it would seem that this manifest content of consciousness became vitiated, and that the image or symbol represented in the spoken word too often lost its primarily common meaning. Apparently, with the introduction of the moralistic image of self, that is, the image or symbol expressed in the individual's 'good' or 'bad' appearance or behaviour and its private advantage or disadvantage to the individual, his attention became deflected from a socially common meaning or function to a private interest or wish. Instead of mediating always a common content of meaning, these social symbols were made to serve at times wholly personal, proprietary ends. So that in addition to the common content of meaning there is introduced a personal, proprietary content. While the manifest content of the spoken word remains intact as a common symbol, in so far as it has become influenced by this personal image, a wholly arbitrary and private meaning necessarily attaches to it.

In this miscarriage of the social image and in the deflection of attention it entails, the social organism has been seriously affected in its intrinsic economy. As psychopathologists, our interest has centred chiefly in those symbolic distortions and image-substitutions which Freud first traced in the manifest content of the neuroses. But in our social images or meanings there are deflections of attention which indicate a wider

¹ On a Social Approach to Neurotic Conditions, by Hans C. Syz, M.D. *The Journal of Nervous and Mental Diseases*, LXVI, No. 6. December, 1927.

² *The Social Basis of Consciousness*, Kegan Paul, Trench, Trubner and Co., London. Harcourt, Brace and Co., New York.

social impairment. It is this maladjustment among us socially which, it is felt, a group or social analysis contributes to repair.

While, then, it is the function of psychoanalysis and of psychiatry to deal with impressions and images in persons who are mentally ill or definitely ill-adapted socially, group-analysis occupies itself with social images or with images shared among people generally, regardless of whether they are designated as neurotic or normal. It places an emphasis upon the latent content of consciousness as it underlies our manifest social interchange, rather than restricting its inquiry to the reminiscent materials of consciousness as they occur in the isolated expressions of the neurotic or insane individual.

For many years it was my daily experience in personal analyses to pursue diligently the secret phantasies and symbolic irrelevancies of the individual unconscious, hunting them out from their remotest crevices with meticulous painstaking. And there is no doubt that the entertainment afforded my patients in our mutual search for various clues or associations was in many cases sufficiently diverting to constitute what is commonly called a cure. It is true that the individual patient feels that his neurosis, his sense of unworthiness and chagrin, his depression and pain, is caused by unsavoury, irrelevant preoccupations and inept tendencies that characterize him alone. He goes to his physician to receive treatment for a condition peculiar to himself—a condition in which he feels himself isolated from others. And so it was not unnatural that in its development from psychoanalytic traditions the group-method of analysis tended at first also to lay stress upon the habitually repressed, reminiscent material of the individual's unconscious.

In group-analysis, however, the patient is made witness to the situation wherein these irrelevancies and secret excursions constitute a latent tendency that characterizes equally the social group about him. It becomes gradually plain to him that his adoption of a code of symbols possessing only a private latent meaning is a general social condition. He discovers that the common manifest meaning of current social usage is quite as unstable as the manifest content of his restricted personal code. Accordingly, the deflections of attention shown in the substitutions and irrelevancies, the symbolizations and conversions of the neurotic patient are interpreted as being but special manifestations of a deflection of attention existing throughout the social organism.

This interpretation has led to an increasing emphasis upon the factor of the social image as an inducement to the substitutions occurring in individuals of both the neurotic and normal reaction. With the gradual

maturing of the group-method the cherished reminiscences and private ruminations of the individual have come finally to be wholly disregarded. In their stead the latent social content of consciousness, revealed beneath the manifest material represented in the habitual opinions and discussions of social interchange, have become the sole material of analysis. The only concern which occupies the group-analysis is the immediate interrelationship socially of the members composing it as expressed in the symbols of their momentary interchange. It is our group finding that in resolving these social images of common group adoption there follows the automatic restoration of group function in common social activities. For it is the interruption to this co-ordination of function within the social organism which, in our view, is the sole occasion for those states of proprietary symbolization or introversion expressed in the regressions of the neurotic individual.

The reason, therefore, for this inquiry into latent manifestations existing socially—that is, in normal as well as in neurotic persons—is the evidence that the social image of self-awareness, characteristic of the group or community, tends to obstruct the activities of individuals in their natural group inter-functioning; and, further, that those ingrowths toward secret self-satisfaction which we find to be clinically characteristic of the neurotic personality result secondarily from this wider social obstruction.

It is the daily experience of the psychopathologist that a parent brings an ill son or daughter to him for diagnosis and advice. This situation is placed in a very different light if, quite unknown to themselves, the parent of the patient and the household generally are, along with the physician himself, preserving unconsciously among them a social form of repression; and if upon analysis this social repression is shown to be the real cause of the more intense reaction expressed secondarily in the patient. As it bears upon the structure and outcome of mental disorder it makes a very great difference whether the individual patient is from infancy a constitutional neurotic, or whether the barriers to the natural inter-functioning of individuals, as these barriers exist in the social cluster comprising the family, have from childhood obstructed the patient's natural feelings of inter-communication and have forced his attention into the regressive symbols of phantasy and dream.

A programme, therefore, which would seem to me a valuable adjunct to our present endeavours in behalf of neurotic and insane patients would be one which placed upon groups of the community the responsibility of insanity as a social or community problem. Through this

programme the community would endeavour to bring its own latent processes and social images to objective group-observation as a generic group condition. In such groups there would not be the situation in which certain individuals would study other individuals as presumably different in constitution from themselves, but in which all individuals would be equally responsible for the study of a constitutional condition common to all. Such a programme would, I should think, begin among groups composed of the more thoughtful element of the community. It would begin first of all, perhaps, among groups like ourselves whose interest is precisely in the field of psychopathology.

And so, if I may suggest that procedure which would seem to me of value in meeting the conflicts of the individual and the community—conflicts expressed in mental disorder and insanity, in industrial disorders and crime—it would be a programme which most closely affects the interreactions existing among ourselves as components in an economic social organism. This programme, in freeing us from the restrictions of latent social images and repressions, would more and more place ourselves and the community at large upon a common basis of intercommunication and function. In so doing it would render psychopathology less a psychological theory of human interrelationships and make possible the immediate expression of those interrelationships in their physiological actuality.

NOTES ON CASES OF FUGUE¹.

By DOUGLAS BRYAN.

I HAVE been asked to contribute some notes on cases of fugue, but I am afraid that what I have to say will not add anything to the elucidation of this peculiar but very interesting mental state. The first three cases I shall mention I had no opportunity to investigate for any length of time, and the fourth case is still under treatment, though this for the time being is postponed owing to external conditions preventing my seeing the patient at present and thus carrying the investigation of the case as far as possible.

The first case of fugue I saw was I think in 1909 when I was in general practice in Leicester. A man was brought by the police to the Union Workhouse suffering from complete loss of memory. I saw him soon after his admission. The police told me that the man had gone to the police station stating that he did not know who or where he was and remembered nothing of his past life. He had evidently walked a long way and was tired and foot-sore. He was fairly well dressed and spoke well. He looked anxious and worried and said that he was all the time trying to recollect who he was. He had nothing on him that could help in any way to identify him. Questioning elicited nothing of any importance. I took him into the large dining-hall of the Workhouse and he then said "I seem to recollect a large room with a number of people in it at dinner." I suggested a school and various other places but these called forth no response. I tried hypnosis but he was not hypnotizable or apparently suggestible. He slept badly the three nights he was in the Workhouse as he was all the time worrying about his condition. The police had circulated his description and photograph. Three days later a police sergeant from a neighbouring part of the county came to the Workhouse and on seeing the man said to him "You are Mr so-and-so." The man immediately replied, "Yes" and therewith his memory gradually came back. He said that for some time he had been worried about his financial affairs and had become very depressed. He was a schoolmaster and married. On the morning of the day he found

¹ Read at a meeting of the Medical Section of the British Psychological Society on April 25th, 1928.

himself at Leicester he had left home with the intention of committing suicide by drowning. He had carefully dressed himself so that when his body was found he had hoped he would be buried without it being known who he was. Apparently soon after he set out that morning his mind became a blank and he wandered on for many miles till he went to the police at Leicester. I did not see the man again.

The next case I saw occurred a few years later in 1913. This man was brought to the Leicester Union Workhouse and I saw him soon after his admission. He told me that he suddenly found himself sitting in a church in the town of Leicester. He did not know how he got there or who he was. He was very tired and hungry and foot-sore. He was rather poorly dressed and not well-educated. He went out of the church and spoke to a policeman who took him to the police station, gave him some food and then brought him to the Workhouse. I could not obtain any information by questioning him and nothing was found on him to help in his identification. The next day I tried to hypnotize him and found him hypnotizable and suggestible, but I could not elicit any information from him under hypnosis. However I gave him the suggestion that he would dream who he was during the night. Next day he told me he had had a dream and that the name Fuggle had occurred in it but he could not remember the dream. However he said he now recollected that his name was Fuggle and that he was married and had a child and that he was a clerk in a tube station in London. I could obtain nothing from him as to the cause of his wandering except that he was worried over financial matters. His wife had been wired for and she took him home the same day, so I had no opportunity of investigating further.

The third case occurred when I was in the Army and stationed at a hospital for 'shell-shock' soldiers. It appeared that this man reported at a base camp one day that he must have lost his memory as he did not know how he had arrived there or from where he had come and he had forgotten all the chief events of his past life. He knew who he was but did not know where his home was, or if his parents were living, or if he were married or single. He was hypnotizable, and under hypnosis most of his memories returned and he gave a detailed and emotional description of shell explosion and his wanderings back to the base camp. He was riding a horse attached to a transport wagon when a shell burst, the horse was killed and he was hurled some distance but not hurt. He was very fond of the horse, and on picking himself up went over to it, knelt down and kissed it. Then it seems he started to walk away,

much upset over the death of the horse, and he remembered nothing more till he arrived at the base camp a few days later. The horse's name was Nell and this was the name of his favourite sister. During the hypnosis, and when detailing the going back to the base camp, it appeared that he was trying to get back to his mother. I only saw the man a few times and under hypnosis he filled in the amnesias, but the real cause of the amnesias I was unable to elucidate.

The fourth case of fugue was sent to me for psycho-analytic treatment two or three years ago and the patient was under regular treatment for about two years, but since then the treatment has only been continued at irregular intervals, and for very short periods at a time, owing to external circumstances which preclude my seeing the patient more regularly.

The patient, a youth aged twenty-three, is an only child. His father is living but his mother is dead. She committed suicide by inhaling coal gas when he was seventeen years of age. For some years she had evidently suffered from delusions of jealousy and persecution, but had not been in a mental hospital. The patient is a clerk and well-educated. When I first saw him he had just recovered from an attack of aphasia which had come on shortly after the fugue and had lasted about six weeks. He was at the time suffering from agraphia. His memory of past events was pretty good except for a few marked gaps, the most remarkable one being that he could remember nothing about his mother or the circumstances of her death. The history of the fugue given me by the father was that the youth, who was a clerk in the City and who had been carrying on his work apparently normally, one evening about two months previously did not return home. Next day the father received notice to proceed to Edinburgh immediately as his son was in hospital there suffering from loss of memory. He went there, brought the youth home, and eventually the patient was sent to me.

The details of the fugue state are as follows: One morning quite suddenly and apparently without premeditation he told the telephone girl at the office at which he was employed to get him a railway timetable, as he had to go that day to the Orkneys, in order to fetch a youth, a friend of his, who had gone mad. He looked up the trains and left the office at his usual time in the evening, met a girl friend as was usual, and they both went home together to the same town. On leaving the girl at the gate of her house the fugue came on. When I first saw the patient he had no recollection of what happened from the time he said good-night to the girl until the next day. What occurred during this

period was recovered during his analysis. After he left the girl, instead of going home, he went up a hill to the railway station. On the way he saw a man trying to force a girl sexually and went for the man, striking him. The girl ran away and the man fled in another direction. I must mention here that this episode has since proved to be a phantasy. He then continued his way up the hill and passed a pillar-box on the edge of the pavement. He sat down by it for a minute or two and was very angry with it. He then got up, arrived at the station and went with his season-ticket to a large main-line station in London. He was living about ten miles outside the metropolis. He went to the booking-office and asked for a ticket through to the Orkneys. He was told he must take a ticket to Edinburgh and book on from there. This he did and travelled with three other people in the compartment as far as Northallerton, and then on to Edinburgh by himself. On arriving at Edinburgh, he walked about and suddenly discovered he had lost his memory. He did not know who he was, why he had come, or how he had come to Edinburgh. He went to the Y.M.C.A. but he was treated curtly and sent to the police station and from there to a hospital. His address was found on him and his father was sent for. He was taken home and gradually he began to remember his past life, but when I first saw him there were large gaps in his memory.

An interesting point in connection with his journey to Edinburgh is, that when I first saw him he was convinced that he had visited Sir Walter Scott's home near Edinburgh and gone over the house. We found later, however, that this could not have happened, because time and trains would not have fitted in. He gave extraordinarily precise and correct details of the house and its contents and we have not yet ascertained the source from which he obtained this knowledge. He had never been to Scotland before and he does not remember having taken any particular interest in it. During the analysis an infantile memory came to light that has to do with Scotland. When the patient was a little boy his mother used to teach him geography. She told him that she thought the map of Scotland looked like a witch. He evidently thought this too, for he associated the Firth of Forth with the witch's sexual organs. The Orkneys were the witch's hat.

Before his mother had mentioned this witch-like appearance of Scotland he had always been afraid of a witch. He had seen the representation of a witch riding a broom-stick in children's books. He was afraid that a witch would come to him and put a spindle into a hole in his chest and turn it in different directions. If the witch turned it one

way he would become blind, another way deaf, and another way dumb. Since the fugue he was at one time deaf for a few hours and at another time dumb for several weeks.

The patient has never had any real sexual attraction to the opposite sex and has never indulged in sexual practice with girls. He has also never shown any inclination to homosexuality. He has practised a certain amount of masturbation which does not seem to have affected him in any way.

The journey to Scotland has an incestuous basis, and this became more and more evident as the analysis proceeded.

His unconscious homosexuality came to expression within a few days of his commencing analytic treatment. He then told me quite spontaneously he had a great fear, when it was suggested that he should have analytic treatment, that the analyst would sexually assault him.

During the analytic treatment he produced certain hysterical symptoms on several occasions just as he got to my consulting rooms. On two occasions he became aphasic, on another he produced a severe attack of epistaxis, and on another a severe attack of hiccoughs. All these symptoms disappeared during the analytic hour. I have reported elsewhere concerning these symptoms¹.

Finally I might mention that a short while ago the patient had a dream in which his mother appeared and accused him of stealing various sums of money from his employers. The next day he discovered a serious defalcation in his accounts which he was able to rectify before discovery. He had no conscious knowledge, however, of stealing the money or what he had done with it. Subsequent analysis brought to light the fact that he had undoubtedly taken the money and put it down the lavatory while in a dissociated state. A full account of this interesting dream I have also reported².

¹ Speech and Castration: Two Unusual Analytic Hours. *International Journal of Psycho-Analysis*, vi, p. 317, 1925.

Epistaxis in a Man Simulating Menstruation. *International Journal of Psycho-Analysis*, vii, p. 79, 1926.

A Dream of Forensic Interest. *International Journal of Psycho-Analysis*, ix, p. 252, 1928.

² A Dream of Forensic Interest. *International Journal of Psycho-Analysis*, ix, p. 227, 1928.

THE EMOTIONAL PROBLEMS OF THE PHYSICALLY HANDICAPPED CHILD¹.

BY FREDERICK H. ALLEN AND GERALD H. J. PEARSON.

(*Philadelphia.*)

INTRODUCTION.

THE relation of physical defects to the development of personality is a subject about which there has collected a considerable amount of speculation and a meagre number of facts based on case studies. The literature is full of vague references to inferiority feelings. The original contribution of Adler postulated that such feelings were based on some organic or physical defect. It has seemed desirable to re-evaluate the relation of physical defects to personality and emotional development, by a study of the life-histories of children with obvious physical deficiencies, and if the influence of the defect seems important, to study its dynamics and its connection with other factors, particularly with the early parent-child relationships.

TYPE OF MATERIAL STUDIED.

As this study was undertaken as an introductory survey of the problem only tentative conclusions have been drawn, but in order to give some definiteness to the results cases presenting marked disabilities of which the patient was aware and which interfered with normal activities were selected.

Twelve patients were studied, seven from the Philadelphia Child Guidance Clinic, two from the Outpatient Dispensary of the Infirmary for Nervous Diseases and three from the Outpatient Department of the Pennsylvania Hospital. The cases from the Child Guidance Clinic were

¹ Read before the 5th Annual Meeting of the Ortho-Psychiatric Society, New York City, Feb. 23, 24, 1928.

behaviour problems, the others were not. The physical disabilities were as follows:

Harelip and cleft palate	1 case
Osteitis, right hip with immobilization	1 case
Bilateral optic atrophy with blindness	2 cases
Ankylosis right elbow	1 case
Poliomyelitis with deformity	3 cases
Friedreich's ataxia	1 case
Pseudo-hypertrophic muscular dystrophy	1 case
Congenital heart disease	1 case
Traumatic hemiplegia	1 case

CASE REPORTS.

CASE 1. Clinic No. 784, J. A., a white boy, aged $7\frac{4}{12}$ years, who was referred to the Philadelphia Child Guidance Clinic because he has difficulty in adjusting with other children and because of petty stealing. He is a homely-looking boy whose facial deformity gives him a stupid appearance. He has a cleft palate and harelip which have been operated on several times unsuccessfully. His left nostril is closed, and the right obstructed. He has a speech defect, particularly in enunciating the sounds *s*, *f*, *g* and *ng*. His eyesight is defective. His i.q. is 119. His behaviour seems the result of a desire to be the centre of attention. Since the age of 3 years he has been stubborn and has had temper tantrums, but these traits have not been so evident since he commenced going to school. When he describes events that have occurred in his environment he depicts himself as playing the leading rôle. He likes to play with other children but appropriates their playthings, annoys the younger and fights with the older ones. He is active in pursuing his own interests, but lazy if asked to do things by his parents. He takes no interest in keeping himself clean and neat and being washed. He adjusts moderately well with the other children in his class at school, but is the largest child there. He is afraid of doctors and resisted strenuously an eye examination because he feared his eye would be removed. He adjusts well with his sister and brother and is generous with both. His school work is good. During the psychological examination he worked eagerly and showed no discouragement. He is interested in mechanical appliances and likes to play with his father's tools. He is interested also in flowers. He is sensitive about his facial appearance. As a young baby his mother lavished much attention on him because of the difficulty in

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feeding him and the care necessary following his two operations, but from his birth she was disappointed in his appearance and has blamed him because his operations have been a drain on the financial resources and have made the management of the household difficult. She admits that this inconsistency in her attitude has been carried over even to the minor details of management.

Through her inconsistency and the separations from his home through his two operations, one when he was one month old and the other during his second year, he seems to have developed a feeling of insecurity in his relation to his mother, and his statement that he is fonder of her than of his father and the fact that he tries to help her in many ways may be an attempt to retain his position with her. His father is interested in his children and proud of his eldest boy. He is more consistent than the mother and the boy obeys him better and shows a desire to imitate him—wants to follow the same occupation, is interested in mechanical apparatus and is fond of playing with his father's tools.

The beginning of his unacceptable behaviour seems to be related to the birth of his sister, which occurred shortly before he was 3 years of age. He is fond of this sister, but as he cannot tolerate another child receiving more attention than he does it is probable that these other children suffer under the jealousy reaction that he cannot direct toward its real object—this sister. Although other children tease him about his appearance this was not so when his unacceptable behaviour commenced, and his stubbornness and temper tantrums have decreased since he began to associate with them.

Summary of Problem. This boy's facial deformity and resulting illness has been an important factor in conditioning the mother's inconsistent attitude toward him. As a result of her inconsistency and the deprivations he has suffered he has never felt secure with her and so was unable to tolerate a rival when one appeared. When the birth of his sister threatened his security he reverted to anger behaviour of an infantile character. As he grew older he carried his desire to be the centre of his mother's interest into his social environment and reacted toward his associates there as if they were rivals. His apparent feeling of inferiority for which he is attempting to compensate by desiring to be the centre of attention is really a jealousy reaction based on a sense of his mother's rejection. He feels that she has rejected him because of the deformity and as a result is sensitive about it. This sensitiveness has been increased by the teasing of his more favoured rivals.

CASE 2. Clinic No. 733, K. M., a white boy, aged $10\frac{7}{12}$ years, referred

to the Philadelphia Child Guidance Clinic by his paternal grandmother because he was disobedient, wilful, destructive and unmanageable at school.

He is a well-developed boy, whose right hip is immobilized by a cast that prevents him sitting comfortably in a chair. His left sole is raised 2 in. and it is necessary for him to use crutches although he can go up and down stairs without them. He is attractive and moves with a vigour that discounts his helplessness in walking. He is alert, cheerful, friendly, usually happy, never complains or cries, persistent, capable of doing things for himself, and during the psychological examination worked attentively, industriously, and with good effort. Some of his mannerisms are effeminate. His I.Q. is 103. His behaviour varies with the persons with whom he comes in contact. He is resistant and defiant toward authority, particularly that of his grandmother and grandmother substitutes (teachers, etc.), and does the things that he knows will annoy them. He has stolen from his grandmother's church envelope and ignored her requests. When he realized that he was going to Atlantic City with his father he became unmanageable and defied her. He coaxes to get his own way, and when he is with adults he contradicts her and is rude. He disliked the Seashore House, objected to the way he was treated, was impudent and unpleasant. He had enuresis there until he was given a urinal.

At every school he has been a conduct problem. He talks out in class and is disobedient and disturbing. With his father he is obedient and companionable. Most of his day is spent in active play with boys of his own age, but he is unable to amuse himself and wants someone with him always.

His present personality seems to have developed on a background in which his paternal grandmother has played the leading rôle. She is a dominating woman who was much attached to her own mother and seems to have been unable to free herself from this attachment. Her attitude to men has been one of attempted domination. She has attempted to dominate the male members of her family, but each member has resisted and defended himself against her. She married a man who was beneath her social station. He has withdrawn himself through his work, etc., from much contact with her. She characterizes her marriage as not completely satisfying. She had two children, the eldest a girl, the second a boy, patient's father. She has attempted to dominate the latter, advising him as to friendships, recreations, occupations and marriage, and he has flouted her domination by doing those things of which she disapproves and spending much of his time away from home. After his

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marriage the couple lived with his parents until the death of the wife. From the grandmother's description there was a close affection between the daughter-in-law, the daughter and herself, and the three were very companionable. The two girls were exceptionally considerate of the grandmother, which is the attitude she demands from everyone with whom she comes in contact.

The patient was left almost entirely to the care of his mother during the first 5 years of his life, as his grandmother's health was poor and his father spent much of the time away from home. His mother was lenient with him and although he was much with her she let him do as he liked. After his mother's sudden death he was cared for by his aunt who was devoted to him. The aunt died 3 years later and the grandmother was greatly upset by her death. She felt unable to keep patient and put him in an orphanage, telling him he would not have had to go there if his behaviour to her had been better. He disliked the orphanage and always wanted to return home. A year later the grandmother thought that he was not receiving proper care and took him out. It was at that time that his hip trouble began. She has imposed many restrictions on his activities for she keeps an immaculate house and will not permit him to upset it. Her greatest concern is to have her own comfort and desires to be respected by everyone with whom she comes in contact.

Summary of Problem. The patient is an active boy who received much affection while young but was allowed to develop his own personality to some degree. He lost in succession both his mother and her substitute and was left to the care of his grandmother who rejected him as she had rejected his father—being unable to dominate the latter and fearing that she could not dominate the former. These rejections made him feel insecure and on his return to the grandmother he attempted to attract her affection by behaving toward her as his father had. As her personality was such that she must dominate and have other people act considerately toward her, this behaviour produced a conflict between the two individuals. The patient found that he could attract her interest best by his resistance to her authority and has carried over that attitude to the school authorities. His hip trouble began about a year ago, but he has not allowed it to interfere with his activities. Both his grandmother and he seem to have accepted it as a natural thing, though it forces her to help him with his bath. His physical disability has offered no avenue to make him more secure with his grandmother, and so has been accepted without influencing his personality to any extent, nor has he developed any feeling of inferiority from it.

CASE 3. Clinic No. 870, F. L., a white boy, aged $8\frac{1}{2}$ years, was referred to the Philadelphia Child Guidance Clinic by the Pennsylvania Institute for the Instruction of the Blind because he is obstinate, always wants his own way, cries much, and is ill-tempered. He is able to perceive light and darkness only, because of a bilateral atrophy which began when he was two years old. His I.Q. is 87. He is a friendly, alert, talkative, restless boy, who gives considerable trouble in his institutional adjustment because he desires to be the centre of attention. In school he repeats poems so quickly and loudly that the other children do not have any opportunity to be heard. In singing he is always two or three notes ahead of the others and he holds the last note for some time after the others have ceased singing. He begins to talk aloud if the children are told to be quiet. He upsets the games and cannot be quieted. No matter what punishment is instituted he always has the last word. If corrected he starts to cry, makes noises and says that he is going to tell his mother, that he is going home and will never come back. He teases and annoys the other children. His work in the class room is good. He is quick to memorize, good in Braille, number and hand work.

Summary of Present Personality. Little is known of his early family relationships. His father was a miner who worked spasmodically. He deserted his wife when the patient was 5 years of age. His mother was immoral. She was abusive to the boy, but he talks a great deal about her and when he is punished always states that he is going back to her. His personality before the onset of his disability is unknown, but when he entered the Institution for the Blind at the age of 5 years he was characterized as obstinate, ill-tempered, and wanting his own way. He cried on the least provocation. He had a good memory but lost interest in any one pursuit quickly. He was the baby of the Institution and was so cute and attractive that he drew everyone's interest. He was made the centre of attention and was humoured in every way. His treatment was inconsistent, some of the matrons petting him and some of them being impatient with him. The other children became very jealous of him and often struck him. His reaction to them was to tell the matrons. For 2 years he was an adorable child, but the third year his cuteness began to wear off and his present behaviour began, so that he is still the centre of attention.

Summary of Problem. This boy's behaviour seems to indicate a desire to be the centre of attention in order to feel secure in his environment. Although the history states that his mother abused him, he seems very

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fond of her and it may be speculated that her attitude to him was an inconsistent one which made him feel unsure of his place in her affection. It would seem from his behaviour on his admission to the Institution that he had found resistiveness the most useful weapon to attract her attention. In the Institution he found a similar inconsistent environment and retained his infantile behaviour as a result. At first because of his attractiveness he received more affection than deprivations and so his behaviour to his superiors was acceptable, but his insecurity at that time is evident from his behaviour toward other children. As he grew older he began to experience a greater degree of deprivation and so reverted to his earlier method of retaining the interest of his mother substitutes. His whole behaviour might be considered a reaction to a feeling of inferiority due to his physical disability, but in the Institution he was competing with children suffering from a similar disability, so that his lack of vision did not constitute a social handicap. It may have increased his dependence on his mother during his early years and so have accentuated the inconsistency of her management, but the latter seems to have had a more distinct effect on the formation of his personality than the former.

CASE 4. Clinic No. 247, T. B., a white boy, aged $9\frac{3}{12}$ years, referred to the Philadelphia Child Guidance Clinic by his mother because he was doing things to annoy his mother and brother constantly; he was jealous of his brother, he was tempestuous, did not adjust with other children, tried to domineer over them, was stubborn, over-active, and did not concentrate. The patient has a depression behind the right ear and two trephine openings in the right occipito-temporal region of the skull, following a mastoiditis and associated meningitis at the age of $3\frac{1}{2}$ years. His right elbow is partly ankylosed so that he cannot straighten it out to the full extent. This has resulted from two fractures at the elbow, the second time occurring a year ago. As a result of the disabled right elbow he is left-handed. His I.Q. is 149. He desires to be the central object of his mother's attention and feels that both his brother and his father are preferred to him. He likes to show off. He desires to be with his family always and dislikes being alone. He sits in his father's chair whenever he gets the opportunity. If his mother and father attempt to talk privately he begins to sing and shout. On several occasions when his noise making has been at its height it has ceased when his mother left the house. On one occasion he attempted to touch his mother's breast. He was not sympathetic toward his mother when she was ill. He expresses nightly a fear that she will leave him. He is jealous of and annoys his brother

and he says that his parents do not love him as they do the latter. He has extended his attitude to his brother to include his associates. He is not teased by his associates but mixes little with them. He does petty things to annoy them. He always has been unwilling to fight, but since his father forced him to fight he has been getting into numerous combats with two or three boys at once. As a result of his emotional difficulties he is abstracted in school and dislikes being bothered. He is heedless and seems to have no real interests. His father was the object of his elder brother's jealousy as he in turn was jealous of his younger brother. He feels that his wife identifies the patient with her father and with himself in those qualities which are distasteful to her. The mother actually prefers her younger son to the patient, although she tries to show her preference for the elder. She tries to ignore his over-activity, but frequently loses her self-control and scolds and yells at him. She fears that he has a lack of moral sense, that he lacks sportsmanly qualities and that he is a coward. She describes the younger boy as one who is everything the patient is not. He is active, talkative, and noisy, but adjusts well with other children and shows no resentment when patient annoys him.

Patient has been away from home on several occasions. The first was at the age of 6, when he attended a summer camp school. He enjoyed his life there, never showed the least resentment at corporal punishment, and on his return home was more respectful and mannerly. Two years ago he lived with a paternal aunt. She was an easy-going individual and had no difficulty with him because she overlooked much of his over-activity. When left in charge of the coloured maid his behaviour is agreeable. Last year he went to camp. At first he was very unpopular, quarrelling much with the other boys. He learned quickly that this behaviour was not advisable and he made the greatest improvement of any boy there. As a baby he was neither fretful nor fussy but unusually active and making constant bids for his mother's attention. His brother was born when patient was 2 years old. Both parents date the appearance of his personality difficulties to the weeks following his mastoiditis. The ankylosis of the elbow seems to have coloured his relation to his companions because though he likes to play ball his associates often refuse him because he cannot play well. He excuses his inability to mix with them on the ground that his deformed elbow prevents him holding his own.

Summary of Problem. This boy's personality seems to have been well established as an infant. At that time he was over-active and desiring

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the whole attention of his mother. If the father's explanation is correct, she had rejected him as a substitute for her husband and her own father. The birth of his brother would increase his feeling of rejection and his desire not to have a rival. The mastoiditis with an increase of the mother's interest due to the seriousness of the illness and her attention to his least cry would teach him a means to attract her attention which he is utilizing still but to a greater degree as his ability to do so as well as his sense of rejection has increased. As a result of her attitude he has developed a feeling of insecurity in her affection and a jealousy reaction against his father, brother and playmates. He utilizes his deformed elbow as an excuse to explain his withdrawal from group activities.

CASE 5. Clinic No. 794, E. L., a white boy, aged $11\frac{8}{12}$ years, referred to the Philadelphia Child Guidance Clinic by his mother because of extreme nervousness, motor disabilities, and the expression of fears that he is being followed. Patient is a boy who shows signs of moderately advanced Friedreich's ataxia, which has affected not only the motor co-ordination of his extremities but has also produced a marked speech defect. The disease process was first noticed when he was 6 years old and seems to have followed a severe attack of diphtheria. His I.Q. is 88. He is a pleasant, co-operative, restless boy who is frank and honest with adults. During the psychological examination he was quiet and attentive, business-like, and showed good effort and understanding. He sleeps well but recently has begun to walk in his sleep. He usually feels too tired to play and lies down instead. His speech becomes worse if anyone looks at him. It annoys him to see anyone chew. He feels blue because the other children are able to play and be at school. He has spells of crying in which he says that life is terrible and that he desires death. He is stubborn, wilful, gets angry easily, and has threatened to kill certain persons. If an attempt is made to get him to eat something he dislikes, he will vomit the food. He is timid, afraid of the dark, afraid to deny accusations, and has terrifying dreams. He is a very imaginative child. He invents improbable yarns in which he takes the leading rôle. His day dreams are of a similar nature. Although he has been out of school for some time, he is certain he can recover the lost ground more easily than other children. He states that he is fond of fishing, rowing, reading—particularly of exciting stories—and of the same type of movies. He feels he is going to get better, that his disability will not handicap him in his adult life, and that if he had adequate training in boxing and running it would be of great assistance to his recovery. He associates with smaller children when he does play with anyone, though usually he

is alone. Formerly his companions were rough boys. He states that he plays much with other boys and prefers to associate with boys older than himself. He occupies most of his time reading or playing indoor games. He attempted basket weaving as a form of occupational therapy but never completed anything he began.

He is very dependent on his mother. He will not eat unless she is present. He will not go to sleep unless she undresses and lies down on the bed with him. He will not go anywhere without her. While with her he is as 'good as gold.' He is very fond of her, more so than he is of his father, and will not let anyone impose on her. He resents the presence in the house of a 1½ year old baby, the child of a boarder. He is an only child, his only sibling having died before his birth. His father is very disappointed in the boy and cries whenever he is mentioned. He is inclined to bully the patient. His mother is unemotional in discussing him but has always been over-protective of him. She worried so much because his bowels did not move during the first few days of his life that her milk disappeared. She has given him his own way in everything, he has been allowed to eat excessive amounts of candy, she would not keep him in bed when advised to do so by the doctor, it was impossible to get her to relinquish her idea of having him tutored at home instead of being sent to a class for crippled children. She escorted him to and from school. Although he slept in his own room from the age of 3 months to 3 years, for several years after he slept with her. Now he sleeps in her room on a cot. The visiting nurse reports, however, that he was left alone a great deal and often was sent on errands to be out of his mother's way. Most of his adult associates have spoiled him, constantly helping to amuse him, and do things for him. His aunt used to frighten him by jumping at him from dark corners.

He was a bright, smiling baby who was only nursed 8 days. He did not gain on breast milk, but did so readily on artificial feedings. At 4 months he had measles and at 9 had whooping cough. He was slow in walking, crawling, and talking. At 3 years of age he had conjunctivitis, then pneumonia, and the same year was struck by a truck but not seriously injured. In his sixth year he had scarlet fever and chickenpox, and in his seventh had a tonsillectomy, was circumcised and suffered the attack of diphtheria which immediately antedated his illness.

The onset of his disability coincided with his first year in school. His absence because of diphtheria forced him to repeat this grade. His teacher was unsympathetic and she frightened him by striking and scolding him because another boy knocked him over. He skipped the

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2 B grade, but in 4 B it was noticed that though he was no behaviour problem and tried hard he was almost unable to write. Although he was absent frequently in 1926 his work was 75 per cent. satisfactory. The next year, however, it had dropped to 50 per cent. and following this he left school. His teachers recently have felt very sorry for him. He is afraid of school and states that the teachers and pupils ridicule him and do not like him. The other boys make him do tricks and behave like a monkey for their amusement. They ridicule him, call him crazy, and make great sport of his awkwardness. He cannot join in their games because he falls. The older boys tease him and blame many of their difficulties on him. He plays with younger children because they do not make fun of him. A negro boy once threatened him with a knife and on one occasion an older boy masturbated him.

Summary of Problem. This boy's mother has adopted always an over-protective attitude toward him. From the first her desire has been to keep him a baby and she has never fostered his ability to grow up. As a result he has become attached to her and so remained at an infantile level of emotional development. His disability has made it difficult for him to hold his own in social situations, and the attitude of both the school and his companions toward him on account of his illness has accentuated his maladjustment. The other traumatic experiences of his life have had a similar effect, *i.e.* to throw him back still more on his mother. So great is his dependence on her that she is unable to satisfy his excessive needs and he is forced to obtain the required extra satisfactions by phantasy. Although his dependence on her would not be so great if the disability and other traumatic experiences had not occurred, his attachment is of such a degree that a normal adult adjustment would have been difficult.

CASE 6. Clinic No. 588, R. B., a white boy, aged $14\frac{1}{2}$ years, referred to the Philadelphia Child Guidance Clinic by the Children's Bureau because he is unable to make a satisfactory adjustment at school and has run away from home once or twice.

Although only 14 years old, patient is as well developed as the average man. There is great atrophy of the right arm and shoulder muscles and a more intense atrophy with lack of growth and deformity of the whole left arm, including the hand. This is the result of an attack of poliomyelitis which occurred when he was 16 months old. His vision is 15.30. His I.Q. is 79. He is a rather mature boy, well-poised, friendly, talkative, and co-operative and pleasant in all tests. He is fond of horses, dislikes reading, and has an urge to do active work and be busy physically.

Adults find him likeable, charming, and are fond of him. With children he has no permanent friendships, he quarrels with, bullies and tries to domineer over them. He has difficulty in conforming to rules, in fact after 8 years in the Home for Crippled Children he had made no improvement in this regard. He dislikes school because he is continually getting into mischief there.

His father had only a grammar school education. He was a salesman but drank so heavily that he could not support his family. His wife left him when patient was 4 years old. His mother is an alert, intelligent woman. She is very concerned about his behaviour and tries hard to understand him. He is very fond of her. The two older brothers of the patient feel he is a stranger. He argues with them and they get irritated. They feel he is a natural born wanderer and nonconformist. His younger sister is very fond of him, as he is of her.

During her pregnancy his mother was distracted and penniless. The delivery was difficult and oxygen had to be administered in order to revive the baby. He was a very sick baby for the first 6 months and his mother was worried because she thought he had hydrocephalus. He had temper tantrums when he was 10 months old. At 16 months of age he had his attack of poliomyelitis which paralysed both arms and affected his speech. On his recovery from this he was placed during the day in a day nursery while his mother worked. At the age of 3 he was put in the Home for Crippled Children, where he remained till he was 11 years old.

He hated school from the start. He began when he was 6 years old and at the age of 12 had only reached the third grade. He is fond of his home and expresses no dissatisfaction with it. He seems to disregard his disability. He talks about it in an off-hand manner. Despite his disability he has no fear of physical combats. Since the time of his study at the Clinic he has left school and embarked on a cartage business. He has done well and now he has two teams and a helper. He contributes handsomely to his mother's support and seems well adjusted and happy.

Summary of Problem. During his early life his mother was under great emotional strain because of her husband's behaviour. As a result her interest centred about the boy and this was increased by the latter's ill-health. Her over-solicitude seems to have developed in him a resistance to authority and unfitted him to conform to routine, if that routine was distasteful. His temper tantrums at the age of 10 months seem to indicate that his mode of behaviour was already formed then. While very young he suffered three serious traumatic experiences within a

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period of two years—his illness, the birth of his sister, and his admission to the Home for Crippled Children. (The last two events tended to deprive him of his mother's affection.) His actions to the other children in the Home seem the result of jealousy because he was not the main object of interest there that he had been with his mother. His maladjustment at school seems to have become serious after his discharge from the Home and this seems the result of a number of factors. While in the Home he had been associated with children as disabled as he was, so that he was not an outstanding member of the group. Outside the Home he would be—but he would be made more conspicuous still by his large size and his presence at 12 years of age in the third grade. These three factors accentuated by the difficulty he found in his school work made school an unpleasant place, and he felt he must get away from it. His return to his home would reactivate his desire to be the central person—the one on whom his mother should depend—and this would tend to inculcate the desire to leave school and get a position where he could be happy and also could contribute to her support. His physical disability seems to have been only one factor in influencing his desire to leave school, but it probably accentuated also his mother's earlier over-protective attitude. This boy's desire to reach maturity quickly may have been a compensation for an inferiority feeling as a result of his defect.

CASE 7. Clinic No. 628, C. S., a white boy, aged $15\frac{8}{12}$ years, who was referred to the Philadelphia Child Guidance Clinic by the Pennsylvania Institution for the Instruction of the Blind because he truants from school, forging written and telephone excuses for his absence, and because he indulges in petty stealing and exaggerates. His left eye is totally blind, and he is able to perceive only hand movements at 6 cm. with his right eye. This condition is due to bilateral optic atrophy following a severe attack of typhoid fever when he was $2\frac{1}{2}$ years old. His i.q. is between 89 and 94. He is friendly, has an easy social manner and talks freely. He is interested in describing his work and his occupations and is especially interested in church work, being a member of the choir, and radio. He likes to be with other boys and is beginning to show some interest in girls. In school he has a difficulty in sitting still for a long period and wants to be helping someone always. He does not stand out from the group of boys he is associated with. He does poorly in algebra and tends to be untruthful about his marks. He attempts to stay out of school as much as he can, impersonating his parents and teachers over the phone and in writing to make excuses for his absence. His stealing began when he entered kindergarten, only occurs at school, and seems

connected with sex behaviour with another boy. He has never been a behaviour problem at home.

He is a very nervous boy and is characterized as a great home body. He is over-sensitive to criticism, and he is less mature than other boys of his age. He has difficulty in adjusting himself to new situations. When he gets discouraged about graduating he feels he should stop school and go to work at once. He has confessed to things he did not do.

His father is a dwarfed, feeble, garrulous man who was gay in his youth. He prides himself on having paid back all slights and of being exacting and particular. He is a letter carrier who takes pride in his record. He loves to tell an embellished story. He never receives any help from his children because he criticizes them if they make a mistake. He is irritable with them, especially with the patient. He expects the same behaviour from him as he does from the other children. Patient likes to help him but at the first reprimand he becomes sensitive. If his father criticizes him he becomes upset and says that no one cares for him. His father becomes irritated because patient frequents the society of his elder step-brother who is boastful and who tells patient that algebra is a useless subject.

His mother is interested exclusively in her home and family. She has a benign attitude to her husband as well as to her children. She indulges patient as a compensation for his father's harshness. She is disappointed about his blindness and feels he will never amount to anything. He interprets her lenience as a feeling on her part that she wants him out of the way.

Patient is the oldest child. He is very devoted to his sister, who resembles his mother, and was very worried when she was ill. When he first became blind his mother was sorry that he lived. She thinks he will never amount to anything. She indulges him because of his disability. In the past she has urged him to play with other children, and when he would come in crying because he could not compete with them she would send him out again. His father has treated him as he has the other children, making no exception because of his disability. He has been the only blind person in the town in which he lives. The young people there are considerate and kind to him and urge him to take part in social functions. Sometimes when he was younger he would be told by the other children to go home because he could not play properly on account of his vision. He is popular at school and picks a superior group of boys as friends. He feels that his sight is improving and hopes that it will continue to do so, but he is beginning to accept the probability that it

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will never be as good as that of his companions. As a child it was a bitter burden to hear the other children playing happily and feel he was unable to take part. Before he went to school he had attacks of depression, when he gravely doubted if he would ever amount to anything. These have disappeared since he started school.

Summary of Problem. In many ways this boy has never developed emotionally beyond an infantile stage. He finds his greatest satisfactions in his home and his home surroundings. When he meets a new or difficult situation he tries to avoid it by returning to his home. His mother seems to have fostered his immaturity because of her need for a love object which she could dominate. In order to retain him at an infantile level she has over-protected and indulged him and his disability opened a more natural reason for her continuance of this sheltering attitude to him. His father has attempted to treat him as he treats the other children, but this treatment was harsh to the over-protected boy and he fled from him to his mother. He sensed her feeling that he must be a failure (a wish on her part that he might remain an infant) and adopted her attitude toward his disability. He sensed that her feeling about his disability was also a rejection and he was the battle-ground of two desires—the desire to grow (as a result of her rejection) and to remain an infant (as a result of her protection)—during the pre-school period which produced his attacks of depression. In the Institution for the Blind he was removed from her influence but was still protected. Whenever new or difficult situations rose he felt unable to meet them and desired to return to his one source of security—his mother. It is probable that had he been forced to enter a less protected life his personality defect would have been more evident earlier. In this case the over-protective attitude on the part of the mother produced a strong infantile attachment to her, but the disability enabled this attachment to remain long past the infantile period of life.

CASE 8. Infirmary for Nervous Diseases, No. 69988, S. S., a white boy, aged $5\frac{1}{2}$ years, referred by his mother to the Out-Patient Department of the Infirmary for Nervous Diseases because he had difficulty in walking.

He shows marked signs of pseudo-hypertrophic muscular dystrophy. The disease began when he was between 2 and 3 years of age. He is irritable, restless, playful, has temper tantrums when refused any desire, and screams loudly. At the examination he kicked and twisted in his chair and refused to obey any request. He is mean with other children, does not play normally, and prefers breaking and throwing things around.

He did not talk until he was over 2 years old and preferred to use gestures rather than speech. He had whooping cough at 2½ years and has talked less well since. He has had good control over his bladder and bowels since he was 2 years old. He is very much attached to his mother and she has no control over him unless she beats him. Whenever he awakens he cries loudly for her. He demands that his drink of milk be served in a bottle. He is obedient to his father. When he was 2 years old his sister was born. He hates her intensely and has done so since birth. He fights with her continuously.

Summary of Problem. This boy has a strong attachment to his mother. Her discipline has been inconsistent and she has over-protected and indulged him. The birth of his sister made him feel less secure in her affection and he has adopted an infantile reaction to attract her attention and a jealousy reaction toward his sister and toward other children. It is probable that his disability increased the over-protectiveness of the mother and has rendered this emotionally infantile boy less able to free himself from his babyishness.

CASE 9. Pennsylvania Hospital Out-Patient, No. 6530, J. C., a white boy, aged 4 years, referred to the Out-Patient Department of the Pennsylvania Hospital because he was unable to use his left arm.

There was a flaccid paralysis with atrophy of the left arm, the result of poliomyelitis which occurred 6 months ago. He is able to move his shoulder slightly by the action of the muscles of the back and he has slight movements in his fingers. His I.Q. is 107. Patient is a hyperactive boy whose attention is rather distractible but who maintained his interest during performance tests. He showed no alarm at leaving his mother, although he is a little shy when he first meets strangers. He plays well with his siblings, particularly with his sister of 6 years of age. Owing to the congestion of the streets where he lives he is not permitted to play outside the back yard, but his cousins are frequent visitors and he mixes well with them. He is an obedient child and causes his mother no trouble. He is not selfish. He seldom cries. Not more than the normal amount of quarrelling occurs among the four children in the family.

His father is dead. His mother, aged 41, seems to have filled the place of both parents. She believes that children should be trained to obey orders as long as the orders are reasonable. She does not permit the older children to stay out late at night nor does she allow them to go too frequently to the movies.

The patient awoke one morning and noticed that his left arm was useless. Sometimes he comments on it, always with the statement that

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it is getting better. His mother has adopted the same attitude and never mentions it except in an optimistic way. She can see no change in the child's behaviour or personality since the disability occurred. She only comments on one peculiarity, and that has been present always, i.e. he is shy when he first meets strangers—which trait is characteristic of herself. There are never a large number of visitors to the house and patient is not accustomed to much noise and excitement.

Summary of Problem. Patient is a well-adjusted boy. His mother seems to have filled the rôle of both parents in a very normal manner. She has adopted an objective attitude toward the disability and the boy—who seems modelling himself on her—is adopting the same attitude. Although he takes part in group activities, he does not feel his disability singles him out as different from other children.

CASE 10. O. P. D., No. 7969, F. K., a white girl, aged 12 years, referred to the Out-Patient Department of the Pennsylvania Hospital because she was bow-legged and suffered from shortness of breath.

She has a congenital pulmonary stenosis with a patulous ductus arteriosus. She is cyanotic, there is a harsh systolic murmur at the apex and at the base; the base of the heart is widened. The bow-legged condition is due to defective development of the pelvis with failure of the pubes to unite. There is partial atrophy of the bladder. She has a sub-acute otitis and badly infected tonsils. She is over-weight for her height which is considerably under the normal for her age. Her broad shoulders and short bowed legs encased in braces give her a distinctly peculiar appearance. This appearance seems to have made an unfavourable impression on several of her physicians who characterize her as backward. From her conversation, however, one gets the impression that her mentality is within normal limits for her social and educational advantages. When she was examined first, it was almost impossible to do a thorough examination because of her crying and resistiveness. A year later it was noted that she still cried a lot. The following year she started school and is now in 3 A. She is a well-poised, outgoing, not bashful, self-possessed child. She shows no undue interest or embarrassment about her heart or legs. She says that she gets breathless on the least exertion. This is due to her weak heart which has been weak since her birth. Except for the breathlessness her heart does not bother her, though at one time she had considerable pain. She would rather have her heart fixed than her legs, for the latter bother her not at all. She has not considered what occupation she will follow when she grows up or if she will marry. It will be time to think of that when she gets 16.

In response to three wishes she answered that she desired first to be a bookkeeper, second a stenographer, third a typist. She sleeps well and never dreams. She has many friends, in fact all the girls in her room like her, but she has two special friends. Both these girls are cripples, her second best friend being more crippled than she is. Both her friends are crippled because she attends the school for crippled children and there are many children there whose condition is much worse than her own. She helps them with their wraps and in getting about, and she assists the teachers also. Formerly she went to the public school, but the other children were not careful of her and several times she was pushed down.

She likes her father and mother equally. Her eldest brother is 18 years old, her eldest sister 16. She has a brother of 13 who is a good boy but quite wild. He runs about the house, shouts, and makes all kinds of noise, and patient objects and shouts at him to keep quiet. He gets mad then and they fight. The two of them fight very often. This brother teases and torments patient's younger sister aged 9. Patient is fond of this sister and never quarrels with her. Patient is the smallest child in the family and she would like to be tall. She looks like her mother and would prefer to do so. Her first memory is of being in the country where there were a number of bad people. She saw a cow there but was not frightened. Her uncle tried to throw her out of the window but her mother prevented this. She plays checkers, and a circle game that does not entail running. The only times she has been punished of late years was because she ran. She likes sewing, drawing, and checkers. She seldom quarrels with other children. She does not feel badly when the other children run and she has to be a spectator. She would like to have a heart like other people. In drawing her friend Lilian she did not depict any brace or indication of crippling. Her mother says that patient is very fond of housework, in fact she does it as well as a 16-year-old girl. Her mother, who speaks English poorly, commented several times on the child's small size. She blames her illness on the instrumental birth. Often she patted her on the head. The mother says she favours none of her children. Two other children in the family were bow-legged—this has improved with growth.

Summary of Problem. This girl is well poised and well adjusted, although she comes from a family of poor social status. Apparently the mother and father have adopted an objective attitude towards the child's disability—particularly in recent years. Her fear reactions at the time of her first examinations show that she was mildly over-protected, but the large family and the birth of a younger sister seemed to have

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prevented a too-protective attitude on the part of the mother. Her disability may have made her feel a little different from the other children when she attended public school first, but since her admission to the School for Crippled Children she has received sufficient protection to satisfy the small amount of infantilism remaining.

CASE 11. O. P. D., No. 5188, B. T., a white boy, aged 6 years, referred to the Out-Patient Department of the Pennsylvania Hospital because of left hemiplegia. He has a moderate weakness of the left arm and leg and the hand shows lack of development. In walking he drags the left foot. The arm is flaccid and is not carried in the hemiplegic position but shows the characteristic appearance of a hemiplegia of childhood. His disability occurred at the age of 4, when he was run over by a truck. Following this he was unconscious for 2 days. Later because of a fracture of the skull an operation was performed which left a large defect in the skull and was followed by a hernia cerebri. His I.Q. is 120. Patient is a boy with a babyish appearance and a slight lisp. He appears immature. He is rather shy on meeting strangers and apparently has a little difficulty in understanding what is said to him. (His mother has a similar hearing defect.) He does not think he is a big boy for his age, in fact he is small. He would like to be a tall man, as tall as a giant. His arm and leg are weak because he was run over by a truck. It knocked him down and a bone was broken in his head. At school some of the boys bother him, particularly if he tries to sit still. They tickle him. He can run as well as most boys, or almost as well. He plays football and likes it. He plays other "fings." He has a big brother 11 years old and a little baby brother of 3½. He likes the baby and gives him his toys. Sometimes he fights with him. He often plays hide and seek with his brothers. He wants to be a big man when he grows up and work in a shop. Three wishes were first to be big, second to be healthy, third to be strong. He dreams frequently. He has dreamt about the New Year's parade. He dreams also that robbers and crooks catch him. He does not like girls and prefers boys. His best friend is named Edith; she is 8½ years old. His next best friend is named William; he is older than Edith. Both of these children are in his room at school. His father and mother like the baby best, as does his brother. He is fond of drawing. When he draws a picture of himself he makes his left arm longer and thicker than the right and shows himself using it to greater advantage.

According to his mother he has to be dressed and fed on account of his disability. Before the accident he could dress and feed himself—although he was only a baby then. He quarrels slightly with his younger

brother and takes his toys, but returns them if his mother tells him his brother is only a baby. He obeys both his mother and father well and is no trouble. She has noticed no change in his personality since the accident. Both his parents are very worried as to his future. Sometimes he complains that the other children will not play with him, and sometimes he cries about this. Neither of his parents see any change in his condition. His mother is worried about his activities. She takes him to and from school, and though she allows him to play with other children yet she watches closely that no one hurts him or gets him into a fight for fear of injury to his exposed brain.

Summary of Problem. This boy's mother is over-protective of her children. Both she and her husband are greatly worried about the boy's future and feel that he should be worried also—although he is too young to really appreciate his condition. The boy seems to have been developing in a normal manner and his impetus to develop seems to have continued in spite of the attempt of his mother to baby him. Possibly his sense of rejection at the birth of his younger sister interfered with too strong a mother attachment. This impetus to develop has prevented him regressing to an infantile state, but his attachment is forcing him to attempt to compensate and disregard his disability by phantasy rather than by the facing of the real situation. If the over-protective attitude of the parents continues this boy's personality may be crippled.

CASE 12. Infirmary for Nervous Diseases, No. 71744, J. M., a white male, aged 36 years, referred to the Out-Patient Department of the Infirmary for Nervous Diseases because he feared a stroke and thought he would lose his mind.

Patient was a poorly developed man who was brought to the Clinic by his 70-year-old mother. He has a flaccidly paretic right leg with atrophy. This resulted from an attack of poliomyelitis at 2 years of age. He was very ill at that time and his mother worried greatly about him. She was also worried because her husband began to drink about the same period and to be unfaithful, and she seems to have lavished all her affection on this boy. The paralysis made him more dependent on her and this dependence has remained. He has never worked, although the family are in very straightened circumstances. She compels his brothers to support him. He received a moderate education, but has never put it to use. The only interest he has outside of himself is a mild one in politics. Every time he has an ache or pain his mother becomes beside herself with fear that he will have a further attack of infantile paralysis. She speaks of him in his presence the way anyone would speak of a 6-months-

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old infant, and in her presence he behaves as if he were a child. He came to the Clinic on this occasion because he had a headache and feared a return of his infantile paralysis. He was intensely ashamed of his leg, wore high boots and a leather legging under his trousers to hide his deformity. When asked to undress for examination he hesitated before he exposed the leg, saying that he had never showed his deformity to anyone except his mother.

Summary of Problem. This man showed a very infantile attachment to his mother. She has made his paralysis the symbol of his dependence on her and he feels ashamed of it, yet uses it and the fear of a return as means to obtain gratification of all his desires. She encourages his dependence, for when an attempt was made to disabuse his mind of the possibility of a recurrence of his paralysis she became bitterly hostile.

DISCUSSION OF MATERIAL.

In many of these cases, particularly in those who have developed some behaviour problem, there is a tremendous drive on the part of the child to hold infantile, dependent relationships with the parents, especially with the mother. This drive has been conditioned largely by the attitude which the parents have taken toward the physical handicap during the early life of the child or around the time that the condition began. As in physically normal children, this attitude bears a close relation to the parental emotional needs.

In three cases (Cases 5, 7 and 12) the attachment to the mother has been marked and has been so reinforced by the disability and other traumatic experiences that the child has felt little urge to grow up and his emotional development has remained at an infantile level.

In five cases (Cases 1, 2, 3, 4, 8) the behaviour seems the result of a desire to gain attention from the mother or her substitutes, and in four of these five this desire has been so great that the individual has resented the presence of any apparent rival. During the early life of these children the mother's attitude has been an over-protective one and this has been accompanied or followed by a real or apparent rejection.

The over-protective attitude is usually inconsistent and tends to develop a feeling of insecurity in the relationship between the mother and child and this feeling is increased by the rejections. The insecurity toward the love object has forced the child to strive to recover the affection that once was his and so has interfered with his emotional development. He remains infantile and acts accordingly.

Such situations retard the emotional development of children without physical disabilities, and in certain of these cases (such as Cases 3 and 8) it seems probable that the personality defect would have occurred if the child had been normal physically. The relationship between the parents and between the mother and the child has been the real influence that moulded the latter's personality. If the mother's own love life is an unsatisfying one she may need an infantile love object and when the physical disability occurs early in life it becomes one more reason for her attachment to the child because of his helplessness, and it enables her to keep him a baby more easily because it makes the social environment more difficult for his infantilism to face. When the parental love life is satisfying there is no necessity to keep the child an infant, and the physical defect seems to exert little influence on the personality as in Case 10. If the disability produces a grotesque deformity as in Case 1, it may serve as a motivation not only for over-protection but also for rejection.

If the disability occurs after some years, its influence depends on the use the child or the parents make of it. In Cases 2 and 9 both parent and child have maintained an objective attitude to it and it has had little effect on the behaviour although it may be valuable yet to Patient 2 if he can obtain his grandmother's attention through its use. In Case 5 it has increased the mother-child attachment. Patient 11 is torn between two desires. His parents are attempting to use his disability to keep him a baby. He is willing to accede to their desire but has the urge to grow up which he now satisfies through phantasy.

Patient 4 has been unable to face his real trouble—his rejection by his mother—and he blames his inability to mingle in the social activities of his companions on his disability, although the real basis is his own jealousy of other children as substitutes for his father and brother.

The child's feeling about the defect seems coloured largely by the status of his relationship with his mother and by her attitude to the disability. When Cases 9 and 10, in which very objective attitude to serious disabilities was maintained by the parents, are contrasted with some of the others, it will be seen that in the former the child accepts the disability as a fact and not as a defect and so develops little feeling about it, while in the latter—especially in Cases 1, 7 and 12—the opposite is true.

Case 6 seems somewhat different. The physical disability seems to have played an important rôle in producing a desire to grow up and be a man. Although other factors operated here also, the feeling of inferiority resulting from the defect seems to have supplied a greater degree of motivation than in the other cases.

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Comment. The personality of some physically disabled children seems to have been unaffected by their disability, but in others the behaviour seems the result of a feeling of inferiority which shows itself through a desire to be the centre of attention, an inability to face difficult situations, a feeling of shame or uneasiness, or a desire to compensate by attempting to grow up quickly actually or by phantasy. When the relationship between the child and its parents and its effect on the development of the former's personality is studied, it becomes evident that this feeling of inferiority has other causes than the physical defect, although these causes are associated with and at times conditioned by it. In those cases in which the disability occurs early in life the personality seems the result of an attempt on the part of the parents—especially of the mother—to satisfy emotional needs at the expense of the child. If her needs are for an infantile love object, they become increased by her fear that she will lose this through the illness that produces the physical defect. The illness increases the dependence of the child on the mother, and if she desires to keep him in this state the resulting disability makes it easier for her to do so. His increased infantilism makes it difficult for him to face the world, and he will tend to remain passively dependent. The fostering of his infantilism will make him feel subsequent real or apparent separations from his mother more keenly, and instead of these acting as stimuli to development he will react to them by endeavouring by all possible means to maintain his status as a baby. Similar situations tend to produce similar personality defects in healthy children, but they are even more crippling to the disabled child. It is probable that the personality of many of these children would be menaced more seriously did not their disability place them in sheltered situations—such as institutions for the blind, etc.—where they are able to preserve their dependency without suffering too greatly from the conflict with an ordinary social environment.

In only one case in this series did the patient seem to regard his physical disability as an inferiority and to wish to compensate for it by a rapid attainment of maturity.

When the disability occurs later in life the child reacts to it as he has learned to meet new and difficult situations. It may increase his attachment to his mother and so hinder his development. He may be willing to revert to an infantile status and attempt to satisfy his urge to grow up through phantasy. He may accept it as a fact and develop no feeling whatever about it. If it has no value in the family romance, the child may use it as an excuse to explain his undesirable social behaviour.

The child seems to adopt the same attitude to the disability that his parents do. If they worry about it, so does he. If they are ashamed of it, he will be sensitive also. If they regard it in an objective manner, he will accept it as a fact and will not allow it to interfere with his adjustment.

Thus far the emphasis has been laid on the parent-child relationship and the effect of the social environment has not been considered. This has been done purposely because the child seems to regard his social environment as an extension of his family situation. The attitude of his companions reinforces the domestic viewpoint.

The tentative conclusion arising from this study—*i.e.* that physical disabilities affect the personality largely as they influence the relationship between the parent and the child—has an important prophylactic application. If the personality is not to be crippled, therapy should be directed toward the attitudes of the parents to the child at the time the disability occurs. When this is at birth and the parents themselves are well adjusted, they should be encouraged to maintain as objective an attitude as possible toward the child and his defect. Where the parental adjustment is uncertain, active treatment to develop and maintain such an objective attitude should be instituted. When the disability occurs during the early years of life and the parents already have stunted the child's personality, it should be the duty of the attending physician to treat the relationship of the parents to the child and their attitude to the disability as carefully as he treats the illness itself, whereas if a child has been allowed to develop his individuality without being influenced too much by parental needs a serious disability will have little effect on his personality.

CONCLUSIONS.

1. Physical disabilities occurring in the early years of life affect the personality largely as they are utilized by the underlying relationships between the parents and the child. When they occur later in childhood the child reacts to them in the same manner as he has learned to meet other new and difficult situations.

2. It is as essential to treat the relationships between the child and his parents and the attitude of the latter towards the disability at the time of its occurrence, in order that the personality may not be crippled, as it is to treat the disease itself. Such a crippling of the personality is probably a more serious menace to the future happiness of the individual than a very marked physical disability.

REVIEWS

Brain and Mind, or The Nervous System of Man. By R. J. A. BERRY, M.D., F.R.C.S., F.R.S. (Edin.). New York: The Macmillan Company, 1926. Pp. xii + 608.

The subsidiary title of this book is significant. It reveals Professor Berry's belief that when one knows all that is known about the nervous system of man, one knows all that is known about the mind of man. This may be called the neurologists' fallacy; for although it is profoundly untrue, as is very obvious to a reader of this book, it is often found in the writings of neurologists.

If it were our province here to judge this treatise as a purely anatomical or neurological work, we should have nothing but praise for it. In its general plan, in its evolutionary point of view, and in its detailed descriptions of the naked-eye and minute anatomy of the nervous system, it is altogether excellent. So long as he confines himself to purely descriptive anatomy, Dr Berry's writing has much of the precision of statement and terseness of language which characterized the lectures of his great teacher, William Turner; and as a textbook of the anatomy of the nervous system this book has our warmest commendation. But we deplore the marring of a good book by uncalled-for digressions into regions of thought for which the author has apparently no aptitude and of which he has obviously little knowledge.

The title, "Brain and Mind," suggests problems of such difficulty and complexity that we should like to feel assured that anyone who ventures to discuss them is well acquainted with the work of other writers who have dealt with the same topics; and we should expect his references to works on psychology and philosophy to be at least as copious as his references to works on the anatomy and physiology of the brain. We are, therefore, surprised and disappointed to find from Dr Berry's book that writings on the former subjects are either unknown to him or are considered by him unworthy of his attention. A list of 78 references is given on pp. 559-63, and only two of the works cited are by writers on psychology; most of the others are by anatomists, physiologists and psychiatrists. We are, therefore, led to suppose that whatever views Dr Berry may have on the mind and its relation to the brain, they will prove to have little relevance to the views held by those whom we have hitherto looked upon as our natural guides in this field, namely, psychologists and philosophers. Perusal of this book entirely justifies our supposition.

What Dr Berry evidently regards as his main contribution to our knowledge of the mind is his insistence on the dogma, "no neuron, no mind." But even if we accept this dogma—as indeed the great majority of psychologists are quite prepared to do—it does not follow that "neurology is, therefore, the only true psychology and only neurology can explain the phenomena of mind." Indeed, it is obvious that neurology, by itself, can teach us nothing at all about the phenomena of mind. It can tell us much about the 'instrument' of mind and about the 'mechanism' of the instrument through which behaviour is effected, but it cannot tell us anything about the mind itself. The neurologist can, however, point out the site and describe the arrangements of neurons which may reasonably be regarded as subserving certain mental

phenomena, but he has often to fall back on conceptions derived from psychology in support of his opinions. Had there been no 'associationist psychology,' for example, we should perhaps never have heard of 'association areas' in the brain.

In the course of his remarks on the relations of brain and mind, Dr Berry repeatedly refers with scorn to the opinion of some unnamed medical man who has somewhere written that "nothing but hopeless confusion can result from the mixture of brain cells and ideas"; and he thinks "it is nearer the truth to state that it is exactly this divorce which is responsible for the hopeless confusion....If the ideas are not in the brain cells, where are they?" he despairingly asks. The plain man might be excused if he suggested that they are, perhaps, "in the mind."

When we have read all that Dr Berry has to say about the mind we cannot help wondering why he should ever have wanted to say it. We wonder why the anatomist does not stick to his anatomy, as we wonder why the cobbler does not stick to his last. In the words of Gulliver, we "take this quality to spring from a very common infirmity of human nature, inclining us to be more curious and conceited in matters where we have least concern, and for which we are least adapted either by study or nature."

T. W. M.

Psychological Care of Infant and Child. By JOHN B. WATSON, Ph.D. London: George Allen and Unwin, Ltd., 1928. Pp. 157. Price 6s.

A sub-title for this book might be "The He-Man in the Nursery." It breathes vim and vigour, and has a magnificent robustness of notion as to what children should be. Mr Watson might well be described as the 'getter' of education to-day.

The book is disarmingly dedicated to "The First Mother Who Brings Up a Happy Child"; and the happy child is "a child who never cries unless actually stuck by a pin, illustratively speaking; who loses himself in work and play; who quickly learns to overcome the small difficulties in his environment without running to mother, father, nurse, or other adult;...who puts on such habits of politeness and neatness and cleanliness that adults are willing to be around him, at least part of the day;...who puts away two-year-old habits when the third year has to be faced;...and who finally enters manhood so bulwarked with stable work and emotional habits that no adversity can quite overwhelm him."

Or, as it is put in the peroration, Mr Watson hopes to "create a problem-solving child. We believe that a problem-solving technique (which can be trained) plus boundless absorption in activity (which can also be trained) are behaviouristic factors which have worked in many civilizations of the past, and which, so far as we can judge, will work equally well in most types of civilizations that are likely to confront us in the future."

Mr Watson describes the ways in which the behaviourist studies infants and children, and goes on to talk of the fears of children, their rage and tantrums—and "how to control them." He gives a chapter to "the dangers of too much mother love"; and discusses in detail the night- and day-time care of the child, and "what shall I tell my child about sex." On all these points, the book has a wealth of sound practical advice, and will certainly help

parents to reach an objective point of view. Mr Watson's emphasis on education as an objective technique of intelligent 'conditioning,' and the need for calm and unconcern in the educator is a useful corrective to parental anxiety. He is not content with general exhortation, but gives impressive details based on experimental data—as, for example, with regard to the effects of heavy or of gentle handling of the infant. Many of the suggested ways of lessening the emotional element in matters of hygiene and cleanliness, such as refusal to eat, to sleep alone, to control the bladder, and so on, are excellent. In general, Mr Watson's methods would be a vast improvement, from the child's point of view, on those issuing from the muddled thought and tangled feelings of most parents. His intelligence and detachment with regard to the actual means of reaching his educational ends go far to temper the extravagance of those ends themselves. And the insistence on the child's need to play away from his parents would safeguard him from the horror of being all the time with such terribly perfect people.

But all the tributes one is glad to pay to Mr Watson's experimental technique and educational sense cannot hide the serious blunders which spring directly from his habit-mosaic psychology—and perhaps from the robust optimism and simplicity which lie behind it. "The behaviourists believe that there is nothing from within to develop. If you start with a healthy body, the right number of fingers and toes, eyes, and the few elementary movements that are present at birth, you do not need anything else in the way of raw material to make a man, be that man a genius, a cultured gentleman, a rowdy, or a thug." (This list of original possessions is, to the psycho-analyst, suggestively incomplete!)

For Mr Watson, neither the child nor the man has anything 'within.' That is why it is possible for him to quote with approval (p. 141) the mother who bullies her newly-shy boy of nearly five into going on talking about babies. "About a month after this he 'blocked' all questions about babies. This was something new. I said to him: 'Richard, what do you know about where babies come from?' 'I don't know anything.' 'But don't you want to talk about it any more?' 'No.' 'Why not?' 'Anna says it isn't nice to talk about babies.' A few diagrams on paper brought him over to my chair. Then a little talk about how birds lay their eggs in nests, then sit on them to keep them warm—then about how the whole brood hatches out after three weeks, broke down the last resistance. This brought questions about lions and tigers. Finally he took paper and pencil and began to draw lions and tigers with eggs inside them developing into baby lions and tigers."

And the habit psychology allows Mr Watson to believe that straightforward information about sex means that "street-corner talk loses its punch" for little children. This is, of course, simply not true. Little children who have been brought up from the start to frank talk and information, complete with all the scientific terms—penis, vulva, faeces, and the rest—turn eagerly to salacious and secretive jokes, and the usual slang such as 'wee-wee thing,' 'bottom,' etc., when they get the chance.

But Mr Watson's optimism carries him even beyond this. "The child whose knowledge has been made full and complete passes into adolescence, the years from twelve to eighteen, without shock. . . . Adolescence should not be any different from any other stretch of years." To what depths of blindness, factual, biological, sociological, will not a simple trust in habit take one!

But alas! for the habit psychology—the less simple truth breaks through

here and there. Apropos of infantile masturbation after good practical advice, it is admitted that "a child of six or eight, badly brought up, associating with your child of four can fast make a wreck of your most careful efforts." And again—"In spite of it [your careful training], this form of sex outlet [masturbation] will be utilized during adolescence." How can either of these things be, if there is "nothing within," and the proper habits have been properly built up? From whence does the "badly brought up" child of six or eight gain this magic hold over your child, after "all your careful efforts"? It is a mysterious power he wields, hard to understand on any mere habit psychology. And how inconsiderate of the well-trained child to find something in himself stronger than your careful conditioning, when he reaches adolescence! Where does this need for a 'sex outlet' come from? Can it be that he suddenly develops an inside, after all? Or that he had one all the time, and you were too busy with your habit-conditioning to notice it?

We suggest to Mr Watson that to overlook the intense inner conflict of the little child about these subjects of 'frank information,' particularly when the person bullying him into talk is his mother, is a form of cruel blunder, a rough handling of the mind, that is possibly even more important than handling his body roughly when an infant.

SUSAN ISAACS.

*A Text-Book of Psychiatry for Students and Practitioners*¹. By D. K. HENDERSON, M.D. (Edin.), F.R.F.P.S. (Glas.) and R. D. GILLESPIE, M.D. (Glas.), D.P.M. (Lond.). London: Oxford University Press, 1927. Demy 8vo. Pp. x + 520. Price 18s. net.

§ 1. Textbooks may be put in an historical series which falls into periods. In the case of psychiatry there are three clearly discernible periods: first, that of descriptions of and classification by symptoms; second, descriptions of and classification by the course of the diseases; and third, an approach to the subject of mental disorders based on psychopathology or on some notion that will serve to correlate the disorders and the symptoms on some basis other than superficial resemblances. This last is the class with the most members. It does not help the student to ally examination-anxiety and seldom helps the practitioner in deciding to certify, but it does make for an interest in psychiatry that overcomes the great obstacle of inertia.

The feature which qualifies a book for the third class may be neurological mysticism, or the vigorous speculations on biological adaptation, or the efforts of the psycho-analysts (except that none of them have yet written a textbook of psychiatry on this basis)—whatever approach is taken the result will, from one point of view, be the same, the reader will be forced to connect up the diseases with one another in an intelligible way.

Granted the presence of such a connecting link as a diagnostic sign for the third historical grouping, we must further examine to see how persistently the author uses his new instrument of thought, his neurological, psychopathological idea or whatever it be. A topographical survey of the book will

¹ [Why are practitioners classed with students on the title-pages of these books? Does it not reveal a lamentable absence of post-graduate training that one book should ever be thought suitable for both classes? J.R.]

give the answer to this further question, for if the new notion is only referred to in the Introduction the author is obviously only paying lip service to what he has the grace to regard as an intellectual virtue. If he refers to his notion at the end of each chapter on the various diseases, he is making an attempt to be thorough in a half-convinced way. If he rearranges his material (or rather let us say Kraepelin's material) to exploit his theory to the uttermost, we hail him as an enthusiast with the courage of his convictions, a danger to the student and a potential saviour of the profession!

§ 2. The patient reader will now ask where the book under review comes in the categories mentioned. Is it of the Kraepelin or post-Kraepelin¹ period? Does it display its new theories in the Introduction or do these permeate every line of the book?

It is a compromise, that is to say, it is not carried away by any theory but neither does it leave one with that hunger to try out the views put forward on the details of clinical material which marks the epoch-making textbooks. In the endeavour to give the student a fair survey of the leading views of all schools some of them are sadly garbled, particularly the Freudian, which is recognizable only because certain words are used, not because the underlying ideas are comprehended.

§ 3. The foregoing considerations have no utility in guiding a student. They are of service—if at all—only in respect to the future of the psychiatric service in this country. The book is one of the best of its kind. That it is out of date in several respects is the sad fate of all textbooks. The underlying theme is that of reaction types, but this valuable idea is allowed to inhibit detailed investigation. Meyer's view that a psychoneurosis is a part-reaction while a psychosis is a total one calls out for further elucidation of the special part affected in the former, and on clinical evidence we may assert that many psychotics do not seem to have wholly disordered personalities.

Treatment is adequately dealt with as regards the body but the fact of transference, surely an important clue to biological adaptation, is omitted as a factor in psychotherapy; the experimental test of transference capacity as a diagnostic and prognostic aid is also omitted. Indeed the utilization of any view on psychopathology is not systematic and thorough, so that none is done full justice, but then textbooks seldom do.

It is not stimulating, but it is conscientious, and that is a very great merit in a book on psychiatry.

J. R.

Sex and Repression in Savage Society. By B. MALINOWSKI. London: Kegan Paul, Trench, Trubner & Co. 1926. Pp. xix + 285. Price 12s. 6d. net.

European Christendom during two millenniums accepted with complacent resignation the belief that mankind, more particularly woman, was sinful. That sinfulness implied sexuality, and that to be immoral implied to be libidinous, that is to say, to take pleasure in sexual activity. The inevitability of sin was implicit in the theological doctrine that it was 'original.' Purity or

¹ Kraepelin's strength lay in his persistent employment of the classification by *clinical course* and his refusal to be drawn off into speculations that would disturb his impression of his ever more complicated but very useful clinical types.

sinlessness was attainable only when we were completely emancipated from all promptings of the world, the flesh and the sexual organs. It followed that on earth, apart from sexual anaesthesia, moral purity was most nearly attainable by repentance after indulgence, by the cancelling as it were of the pleasurable and sinful emotions by overlaying them with painful ones. This latter process, Freud, without stopping to discuss the theological problem, terms 'repression,' translating Divine inhibitions and the promptings of conscience into that soulless figment the 'endopsychic censor.' Freud's discovery, or rather his formulation, of repression and conflict arose out of his clinical study of neurotics. The conflict determining a neurosis is always, in his well-known theory, ultimately and in origin of a sexual nature and its sexuality is traceable to a child's early relation to its parents, to a boy's jealous, though maybe unconscious, hatred of his father and attachment to his mother, or to a girl's attachment to her father. From its early beginnings in European clinics the theory has grown until it has been applied to every community in every stage of culture, and at all times all over the world. Competent anthropologists have generally resented this incursion into the wider field of myth, magic and tradition, of the theory which, whatever measure of validity it may have in the peculiar social settings of its European origin, has never proved its right to interpret the institutions and behaviour of peoples whose type of society differs from our own. They had not, however, as yet very clearly or unanimously formulated their critical objections to it.

At last, however, we have before us the first thoroughly scientific *exposé* of the problems of psycho-analysis applied to a primitive community by a peculiarly qualified anthropologist. An exceptionally intimate knowledge of the Trobriand language, a long term of residence among the natives and a rigorous method make Dr Malinowski's work a milestone in the history of sociology which no future worker can afford to neglect.

With irresistible logic he shows that the 'Oedipus complex' of the Freudian theory is essentially patriarchal in character, inseparably related to the sort of dominant-father type of family found in European-Christian communities, and that it cannot be traced in the matrilineal type of society of which he gives us so detailed and searching an example. Neither can we legitimately derive from this particular type of patriarchal complex any indubitable indications of a hypothetical prehistoric state of group-marriage or promiscuity. Dr Malinowski shows, too, that the puritanical repressions of the sexual impulse that are so prolific a source of neurotic disorders in Europe have no parallels in the sexually freer matrilineal society of the Trobriand islanders. Amongst these people it is the maternal uncle living in another house who wields authority over his nephew, the father plays the rôle of trusted friend whose authority is exercised elsewhere. In short he has proved that it is the particular cultural situation, the sort of social organization, which determines the type of family pattern or 'nuclear complex,' which in its turn determines the conflicts and repressions that psycho-analysis deals with. Thus in a father-right society, such as our own, the conflicts and repressions will be of a different nature to those in a mother-right society, where descent is traced through the mother and where the *potestas* is exercised by the maternal uncle.

It would be wrong to suppose, however, that there can be only two types of family pattern or 'nuclear complex'—one father-right type of complex and one mother-right type of complex. Dr Malinowski suggests, though perhaps without quite sufficiently making it clear, that there are at least as

many family-constellation patterns as there are different types of social organization. Mother-right may be matrilineal or patrilineal. In a matrilineal community the father may be the familiar inmate and daily companion, or a visitor who lives chiefly in his mother's family, or there may be father-right communities where the maternal uncle still exercises some authority.

But the possible variations in the family-constellation with their corresponding chances of producing conflicts, of inspiring the substance of myths, of sayings, and of dreams, are not limited to the formally classified and recognized types of social organization. The type of family-constellation varies within the same social organization, and this is where we think that Dr Malinowski might with advantage have developed his theme—even though this might have meant some slight modification in his theoretical treatment.

This latter consideration might have led to a most interesting analysis of the dissimilar types of conflict provoked in the offspring by variations (in our own nominally patriarchal society) in the respective dominating or submissive tendencies of the two parents. We must consider to what extent reactions and conflicts in daughters and sons are modified by a reversal in the power-exercising rôles of father and mother. We are sufficiently familiar with the domineering 'matriarch' and her irresponsible pliant husband, and the resulting fierce and bitter resentment of daughters and sometimes of sons. On the other hand, do we know to what extent a too dominating and repressive father will foster in his son a resentment and fear which in after life find compensation in espousing 'feminist' or 'power-for-women' causes, and which foster a masochistic tendency, and so in its turn tend to modify the current social theory of the father's *potestas*?

GEORGE PITT-RIVERS.

The Unconscious in Action—Its Influence upon Education. By BARBARA LOW.
London: University of London Press, 1928. Pp. 226. Price 5s. net.

Miss Low's aim is to "show the bearing of Psycho-analysis on education"; and particularly to make clear to the teacher some of the changes which go on in the child's mind while he is being educated, and what the actual relations of teacher and child may be, as seen by psycho-analysts.

At this time of day, we may reasonably test any book announcing such a purpose by certain quite definite standards. We may expect to find, in the first place, that the various technical terms, indispensable within psychological science itself, are fully translated into concrete every-day language—since this is both the test by which the writer's own scientific knowledge is shown to be thoroughly immediate and usable, and the only way in which it can be made available for the non-technical reader to whom the book is addressed. And, in the second place, we may expect such a book to be full of the meat of detailed homely fact, rather than of the bones of generalization.

The earlier chapters of this book seem to us not quite to pass these tests. There is in them too much general statement in a technical form which must be quite familiar to anyone who has read anything at all of psycho-analysis, and unhelpful to anyone who has not; and the structure of the book as a whole seems to lend itself somewhat to the mere repetition of formulae. But the later chapters, in which Miss Low gets down to her admirably detailed illustrations, are full of facts and suggestions which must make every teacher

who reads it pause to think over his own experience and the children he has taught. When she breaks away from the hypnotism of technical terms, and writes out of herself, Miss Low can write with a most convincing concreteness, clarity and vividness; as in the passage in which she compares the flow of the emotions with the history of a mountain spring; or her account of the omnipresence of guilt. She has the happiest gift for letting others speak for her, as when she quotes

"If she be not fair to me,
What care I how fair she be?"

as "the cry of all instinctual life."

And she has certainly succeeded in making clear the vast psychological complexity of those educational problems (co-education, sex instruction, sports and games, and the actual technique of teaching), which are more usually looked at from the upper surface only.

Her account of the possible ways in which the informed teacher might co-operate with the technical analyst is very clear and suggestive. While carefully repudiating the notion that the teacher can do the work of actual analysis, Miss Low looks to him to know when children need analysis, conceiving his relation with the expert psychologist as exactly parallel to his relation with the school doctor. She does not, however, make clear why the teacher cannot analyze the children he teaches, nor show the psychological reasons for holding that he could not do so even if he were trained and experienced as an analyst of other children.

Prof. Nunn writes a commending Foreword to the book.

SUSAN ISAACS.

The Behaviour of Young Children of the same Family. By BLANCHE C. WEILL, Ed.D. Harvard University Press; and London: Humphrey Milford, 1928. Pp. x + 220.

The main thesis of this book is a very important one. Advocates of nature against nurture have often drawn our attention to the differences occurring among children "in the same environment"—i.e. in the same family. Parents themselves are often at a loss to account for the differences of personal gift or morality to be seen among their children, saying "They had just the same bringing up." This book sets out to show, in a series of detailed studies, how no two children, older and younger, *can* have "the same bringing up." The psychological circumstances are different for each child, according to his position in the family. Nor can this position, again, be interpreted in any mechanical way. The whole psychological environment of any one child will be a function of the way in which his position of elder or younger (and the amount of age-difference) plays in with the already established psychology of the other children, and of the parents in relation to the different members of the group of children.

This view, which any student of individual histories would be pre-disposed to accept, is amply substantiated by the seventeen case studies given. The book is thus an important contribution to the nature *v.* nurture controversy, and underlines the practical values of the emphasis on nurture.

Interestingly enough, the book succeeds in being important in spite of very inadequate psychological theory. In deliberate statement, the author is

tolerant and eclectic. After surveying recent biological discussions with regard to "the increasing emphasis on the rôle played by environment," she summarizes the different schools of psychological theory in relation to this. As regards the psychology she actually uses, however, her general outlook would seem to be a hybrid of Adlerism and Behaviourism. The explanatory principles used in the description of cases seem to be Adlerian, and the practical advice to be based on Watsonian 're-conditioning.' And, as is so often the case, one feels that her tolerant survey of schools is a substitute for discriminative understanding of their differences, and real assimilation of their common ground. It is thus possible for her to spring upon her readers the bewildered (and bewildering!) remark (p. 191) that "jealousy, which implies a sense of insecurity and anxiety, may have some connection with the development of enuresis and masturbation."

One has strongly the impression that the author does her remedial good work, and presents her cases so effectively, rather by virtue of her concrete perception of human situations than by scientific understanding.

The book is an interesting record of the methods and aims of the Habit Clinics that are now doing most useful practical work in many American cities. It would not be easy to find a more succinct way of summing up the minimal necessities in child training than "unswerving consistency, unconcern when the children are trying to force themselves into the focus of attention, unless the act is really dangerous, the keeping of promises, and telling children the truth."

SUSAN ISAACS.

The Mixed School—A Study of Coeducation. By B. A. HOWARD. London: University of London Press, 1928. Pp. 248.

In this very well-written and sensible book Mr Howard surveys the history of mixed schools, and their position and tendencies to-day, both here and abroad. He then looks at the problem of co-education from the standpoint of the 'moral question,' and of the school in relation to actual conditions in modern society. The facts of sex-differences are well summarized, and the practical issues of the organization, staffing and curriculum of the mixed school are handled with admirable sense and balance.

The aspects of the problem that would be of particular interest to the readers of this *Journal*, however, are scarcely touched upon. The 'moral question' in relation to mixed and single-sex schools is very well discussed, on the basis of the sexual standards and psychological assumptions of most highly socialized people to-day. But there is no attempt to go below these assumptions and trace the deeper individual history of sexual development under the two contrasted sets of conditions.

SUSAN ISAACS.

An Approach to the Psychology of Religion. By J. CYRIL FLOWER, M.A., Ph.D.
 London: Kegan Paul, Trench, Trubner & Co., Ltd., 1927. Pp. xi + 248.
 Price 10s. 6d. net.

The theme of this book is the psychology of religious behaviour. The problem presented is to account for such behaviour in terms of the known mechanisms of the mind. When we ask the psychologist what it is that gives religious significance to any object or situation, the intrinsic religiousness of the object or situation is not in question: that is a problem for religious philosophy. The psychologist is only concerned with the response to the situation and the mental attitude of the responder, for it is this attitude which constitutes religiousness and determines religious behaviour.

Dr Flower's thesis, ably maintained throughout the book, and illustrated from many different sources, is that at a certain stage of mental development man becomes able to discriminate in his environment more than that to which he can effect adequate adjustment by means of his innate or acquired endowments. Far from believing that the religious response is the expression of a specific religious instinct or tendency, as has sometimes been maintained, Dr Flower holds that it is "precisely the outcome of the inadequacy of specific response tendencies." The object or situation to which religious response is made is something discriminated as 'beyond' the range of existing adaptation—a situation in which "the discrimination of unprepared-for elements defeats all existing mechanisms of response" (p. 41).

This feeling of 'beyondness,' in which all the instincts and acquired tendencies are baffled, is a frustration experience which does not lead to conflict, but induces a kind of aching helplessness. This feeling of helplessness Dr Flower regards as the "typical nuclear religious experience." Response of any kind becomes possible only if the situation is fabricated and distorted by fantasy; "equipment not being adequately adjusted to the situation, the situation is taken in hand and fantastically or imaginatively adjusted to the equipment" (p. 41). There is a projection of fantasy upon reality and an attempt thus to bring the situation under practical control. But in so far as fantasy or imaginative interpretation succeeds only in making possible response to part of the situation, and still leaves something unaccountable and 'beyond,' the response is religious.

In support of his thesis Dr Flower devotes a considerable portion of his book to a study of the religion of the Winnebago Indians and to the life and religious experience of the founder of Quakerism. Both of these studies contain much of great interest to the student of the psychology of religion, quite apart from their bearing on Dr Flower's views.

The chapter on Conversion is rather slight and might be regarded as inadequate in view of the importance of this topic in any discussion of the psychology of religion; but it is dealt with only in order to determine how far the known features of the experience confirm or modify the hypothesis advocated in the earlier part of the book.

The chapter on Psychopathology and Religion is hardly adequate to the present position of the subject, but so far as it goes it is a broadminded and tolerant account of views with which the author can have but little sympathy. Much of his criticism of psychopathological interpretations of religion is acute and suggestive, and he has done well in reminding psychologists and psychopathologists that "to show that the mechanisms of projection, trans-

ference, etc., are at work in the religious response does not warrant any conclusion, positive or negative, about the existence or nature of the objective reference of religion" (p. 190).

T. W. M.

Appolonius, or The Present and Future of Psychical Research. By E. N. BENNETT, M.A. London: Kegan Paul, Trench, Trubner & Co., Ltd. Pp. 95. Price 2s. 6d. net.

This volume of the *To-day and To-morrow Series* gives a good, but necessarily brief, account of the present position of Psychical Research and of the obstacles and pitfalls that may be encountered in its pursuit; but it does not tell us much about the course which this line of enquiry is likely to take in the future. But that it will have a future Mr Bennett is very confident, and he bases his confidence on the "veritable revolution" that has occurred within the last few years in the general attitude of science towards the phenomena of the universe. In consequence of this change of attitude the professed student of supernormal phenomena is "no longer denied access to the precincts of orthodox science or received with a dubious welcome," and "can claim and receive a definite status as the representative of an acknowledged branch of scientific study."

In the earlier part of his essay Mr Bennett takes up an attitude of critical scepticism towards the tenets and methods of the spiritualists, and one is somewhat surprised in the end to find how far he himself is inclined to go towards accepting a spiritualistic interpretation of the evidence afforded by Psychical Research. But, as is usual when able men incline towards unorthodox beliefs in these matters, Mr Bennett's bias is a result of long and intimate acquaintance with the facts of Psychical Research, and considerable personal experience of supernormal phenomena. Even at second-hand some experiences may be very impressive. On one occasion Sir William Crookes said to Mr Bennett: "On that very hearthrug where you are standing I saw Home raised eighteen inches from the ground in broad daylight and verified the phenomena *visu et tactu*." No one who knew Sir William Crookes could fail to be impressed by such a declaration.

T. W. M.

Index Psychoanalyticus, 1893-1926. By JOHN RICKMAN, M.A., M.D. The International Psycho-Analytical Library, No. 14. London: Institute of Psycho-Analysis and Hogarth Press, 1928. Published from 52 Tavistock Square, W.C. 1. Medium 8vo. Pp. 276. Price 18s.

This volume gives about 4750 numbered references to original papers and translations, or, if book reviews and abstracts are included, about 10,000. One thousand one hundred and thirty-three authors are quoted from not less than 46 periodicals. Book reviews, abstracts and translations are all signed, the total number of reviewers, abstractors and translators being 203. The references are mainly to English and German, but also to Dutch, French, Hungarian, Italian, Polish, Portuguese, Russian, Spanish and Swedish books and papers.

A careful examination of the Index shows that papers of value are being concentrated in the special quarterly journals, and it is now as rare to find a useful work on psycho-analysis apart from these journals and the library series connected with them as it is to find an important physiological paper appearing elsewhere than in a physiological journal.

Three kinds of type are used to differentiate the German from the English and these again from all other languages, so that the task of reference is made very much easier than it otherwise would be.

There is ample cross-referencing, so that anyone wishing to order a volume of collected papers from a library or bookseller can know precisely what it contains. Dr Rickman is to be congratulated on the production of a very useful work, the preparation of which must have entailed an immense amount of labour.

T. W. M.

General Index from the Fifty-fifth to the Sixty-eighth Volumes (inclusive) of the Journal of Mental Science. By T. W. McDOWALL, M.D. and C. F. F. McDOWALL, M.D. London: J. & A. Churchill, 1928. Pp. 76. Price 2s. 6d.

The Index is under authors and subjects and deals with the years 1909-22. For students referring widely to the literature it is well worth possessing, and those who only make an occasional use of this periodical will do well to bear its existence in mind. It contains about 5600 references.

J. R.

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